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Hospital Management

*A Practical Journal
of Administration*

VOLUME XXXIV—NUMBER 6



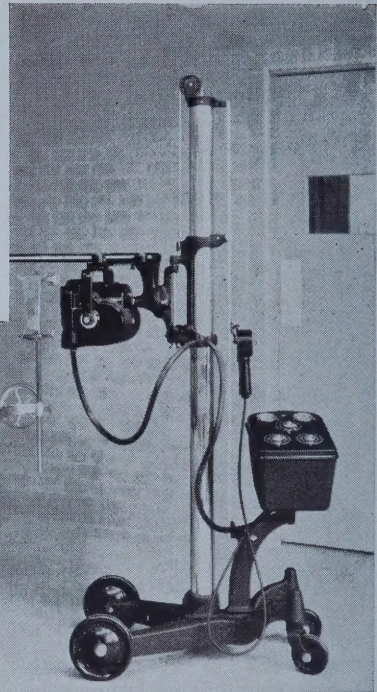
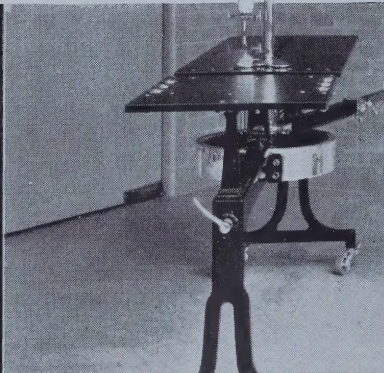
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- ❑ *Medical Costs Committee Endorses Group Insurance, Executives' Training*
- ❑ *The Sacramento Group Insurance Plan*
- ❑ *Keeping House with 80,000 Square Feet*
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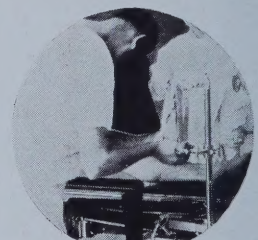
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
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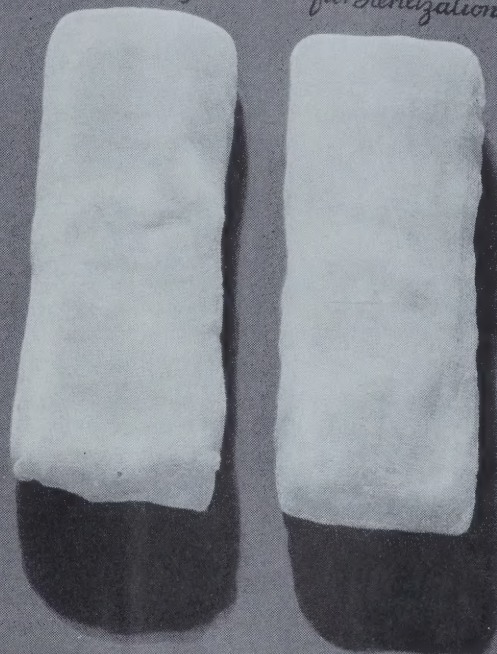
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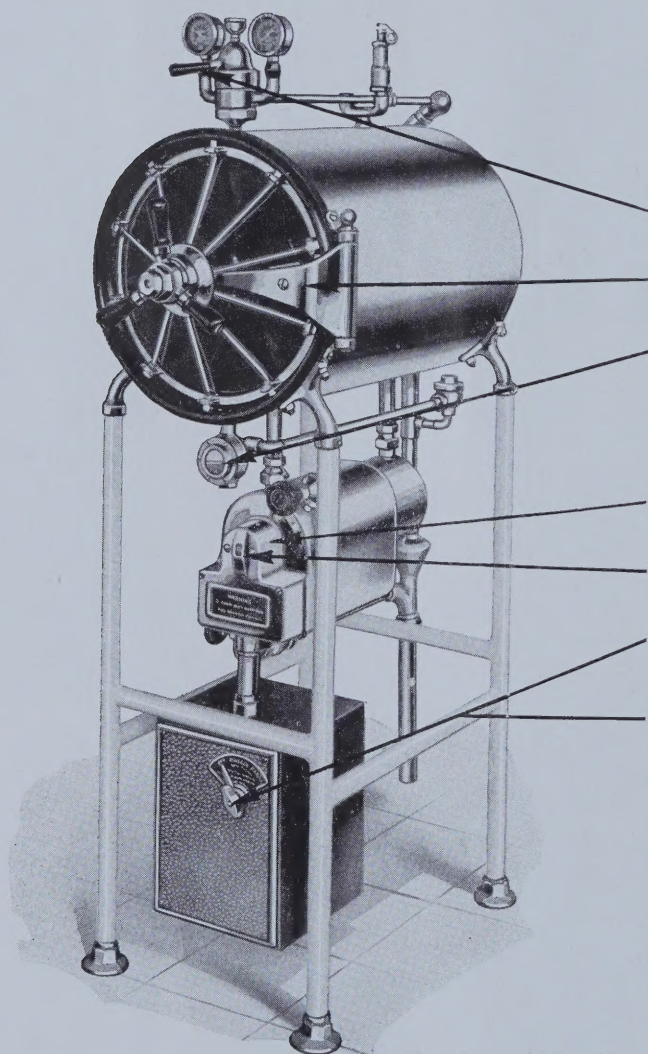
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HOSPITAL MANAGEMENT

A PRACTICAL JOURNAL OF ADMINISTRATION

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Some Letters to the Editor

COMING INTO OWN

Editor, HOSPITAL MANAGEMENT: Your article relative to the recognition by the American College of Surgeons of the able, competent and thoroughly trained superintendent is most worthy of commendation. The superintendent who has been properly trained under a master superintendent, plus many years of personal experience in managing hospitals, is certainly the one who is familiar with the standards of the American College of Surgeons, able to carry them out, and the type any board of directors should be happy to have.

The elimination of an able superintendent to make place for a director or a friend of the directors, either inexperienced, should most certainly be condemned.

The superintendent who has spent most of his life in this special field is at last coming into his own.

Again, many thanks for the publicity to such an interesting article.

SAMUEL G. ASCHER,
Brooklyn, N. Y.

EFFECT OF CUT RATES

Editor, HOSPITAL MANAGEMENT: On the first of June of this year we effected a cut in our hospital rates, which averaged about 20 or 25 per cent. Five dollar rooms were cut to \$4, \$4.25 rooms to \$3.50, and \$3.50 ward beds to \$3. X-ray charges were reduced about 25 per cent. Special nurses' board was reduced from \$1.50 to \$1. Practically every extra charge was reduced accordingly.

In order to meet the inevitable decrease in revenue, we effected a salary cut, averaging 10 per cent. Food costs had already gone down and maintenance costs were lower. The idea prevailed that although the cuts would hardly balance each other, there would be a possibility of increased revenue, due to increase of population. It would seem at the present time that this idea had materialized, for our census in 1931 averaged 41.3, and from June 1 to November 1 our average was 46.2. In fact, the month of July was the heaviest month we have ever had in our history.

Our hospital is owned jointly by the State of New York and the County of Wyoming. Receipts are turned over to the county treasurer each month and all bills are paid by the board of supervisors, the same as any other county bill. At the end of our fiscal year, a statement is rendered, showing the amount of expenditures and receipts, showing a total net deficit. The state reimburses the county for one-half of this deficit. This hospital was a pioneer in making use of this system. There is one other hospital in this state operating similarly. The plan has been in operation over two years and is proving very satisfactory. We service an area which includes our own county of 30,000 and a goodly portion of the adjoining county of 39,000.

We attribute a goodly part of the reason for our success to the fact that we have a unique staff set-up. We have four full time men who are specialists and do not practice without the hospital, the gen-

eral practitioner referring his cases to them, although the general practitioner is allowed to take care of cases himself for medical, minor surgery, and obstetrical service.

W. A. COPELAND,
Superintendent, Wyoming County Community Hospital, Warsaw, N. Y.

WHAT'S YOUR ANSWER?

Editor, HOSPITAL MANAGEMENT: An interesting question came up this morning and I pass it on to you if you wish to use it for HOSPITAL MANAGEMENT.

"Is the hospital the absolute owner of hospital records, including X-ray and laboratory records, or is the hospital only custodian for the patients?"

"If records are made under Dr. No. 1 and kept in the hospital, may Dr. No. 2, after Dr. No. 1 has been dismissed, make use of the records without the consent or permission of Dr. No. 1?"

This question came up in another hospital, and one of the leading men of the city came to my office to get my interpretation. Would be interested in knowing how others decide.

REV. HERMAN L. FRITSCHER,
Director, Milwaukee Hospital,
Milwaukee, Wis.

"SUPER-SUPERINTENDENTS"

Editor, HOSPITAL MANAGEMENT: After reading your article, "Importance of Good Executive Recognized by A. C. S.," I wrote Dr. MacEachern. I enclose a copy of the letter.

You have struck the fundamentally weak spot in the small hospital. Such a scheme would give great support to the good superintendent, improve the weak, and weed out the incompetent.

CARL E. BLACK, M. D.,
Jacksonville, Ill.

[Dr. Black's letter to Dr. MacEachern.]
Dr. M. T. MacEachern, Chicago.—The reading of Matthew O. Foley's article in the November HOSPITAL MANAGEMENT, entitled "Importance of Good Executive Recognized by A. C. S.," has formulated an indefinite idea which has been floating around in my mind for some time. His quotation from the A. C. S. annual report gives the basic idea.

Why would it not be feasible to establish "Superintendents Extraordinary" for groups of small hospitals who would spend one week each year in each subscribing

hospital? Each would study the methods and conditions and at the end of the week have a conference with the trustees, staff and officers, at which he would point out the weak points and suggest the ways in which they could be improved. By some such plan each hospital would be given one week's training each year in better methods. The good points of one would be carried to another and the efficiency of all could be raised. Such a "Superintendent Extraordinary" should be a man who has had a successful experience in managing a small hospital. He should be deeply sympathetic with the problems of the small hospital. He could do much in supporting a good superintendent against unreasonable demands of trustees or staff members and could give all a point of view above and beyond the immediate environment.

Such a man should be easily able to save almost any hospital several times his fee and do much to promote its development and progress.

It seems to me any small hospital could well afford \$150 a year for such a service. This amount would make a salary for at least \$5,000 a year over expenses. He would be a guest in the hospital while conducting his examination.

Several such groups could be organized close enough together so that the expense of travel would not be great.

So much for what may look to you like a crude idea. The small hospital needs help.

THE GOLF TROPHY

Editor, HOSPITAL MANAGEMENT: It has come to my attention that in your magazine you referred to the Golf Trophy played for at the Detroit convention of the American Hospital Association as being "put up by Toronto hospital administrators" for annual contest. The fact is that the Ontario Hospital Association made the presentation to the American Hospital Association and in any future reference to the trophy we hope you will make this clear? The inscription on the trophy reads:

"Presented by the Ontario Hospital Association to the American Hospital Association in Convention in Toronto, Canada, September 1931 for Annual Golf Competition."

FRED. W. ROUTLEY, M. D.,
Hon. Secretary-Treasurer, Ontario Hospital Association.

76 BUSHELS SWEET POTATOES

Editor, HOSPITAL MANAGEMENT: I have just taken in some sweet potatoes on a note, 76 bushels of potatoes. We will have potato pie, baked potatoes, and potatoes every other way. I am trying to trade some to the Red Cross for goods. This past year we have taken in eggs, ducks, chickens, labor, cloth and flour, and I have just got a note from a man who sells crushed stone. The question now is, if you don't have money, what have you?

JAMES MOSS BEELER, M. D.,
Superintendent, Spartanburg General Hospital, Spartanburg, S. C.



WHAT ABOUT INSURANCE?

Editor, HOSPITAL MANAGEMENT: What information have you on hand regarding the operation of an insurance plan to pay hospital service? Have you any information, constitution and prices, rates and dues, etc., for a hospital service association that could be under the management of a group not directly connected with a particular hospital, giving the insured a choice of hospital they could use in case of illness?

Is such insurance popular now in depression times or is it hard to operate at the present time?

B. A. JANSSEN,
Business Manager, Evangelical
Deaconess Hospital, Freeport, Ill.

PER CAPITA COSTS

Editor, HOSPITAL MANAGEMENT: We would very much like to know what is considered a fair daily per capita cost for hospitals of from 75 to 100 beds. We realize there is much difference in the way of figuring costs in hospitals, but would like to know what the average hospitals of the country of the above size are estimating.

ELIZABETH NICHOLS, R. N.,
Superintendent, Nichols Memorial
Hospital, Battle Creek, Mich.

INSURANCE, PUBLICITY

Editor, HOSPITAL MANAGEMENT: I am very much interested in the proposed course in hospital management, particularly as to the length of course, general expense, etc.

The publicity on hospital insurance plans is creating some interest in this community. Please send me any information available.

I am using your newspaper articles and think they are splendid.

WILLEMINA KAPTEYN, R. N.,
Superintendent, Elizabeth Hatton Memorial
Hospital, Grand Haven, Mich.

NEWS FROM IOWA

Editor, HOSPITAL MANAGEMENT: The Iowa Hospital Association is making excellent progress. It has the largest membership in its history. It has a goodly sum in its treasury and \$500 in a special fund to carry out the legislative program this winter. We feel that the officers, trustees, and committees of the association deserve much commendation for their association activities.

CLINTON F. SMITH,
President, Iowa Hospital Association;
Superintendent, Allen Memorial
Hospital, Waterloo.

IGNORE EXPERIENCE

Editor, HOSPITAL MANAGEMENT: Your articles on qualifications of superintendents are most interesting. Many times experienced applicants are ignored by boards which appoint those with absolutely no experience. This is going on in many sections of the country.

JOSEPH PURVIS,
Louisville, Ky.

These pages are for readers who want to ask questions or to comment on anything that interests them from 76 bushels of sweet potatoes to "super-superintendents." Those who would like to get the viewpoint of a number of people on some problem are welcome to present it here, and they also are welcome who only want to pass along some amusing experience or incident.

CAUSE AND EFFECT?

Editor, HOSPITAL MANAGEMENT: I do not know whether it is a coincidence or a matter of fact that I can say that our business has increased since the issuing of the first bulletin and the house has been so full of patients lately that we could hardly handle our business. It has been at least 90% full for the past few weeks and our collections have been unusually good. Our loss of \$1,600 in the recent bank failure here was quite a blow to a small hospital, but certainly our rush of business has helped us to stem the tide and we are still growing strong.

B. A. WILKES, M. D.
Superintendent Missouri Hospital,
Cape Girardeau, Mo.

A GREAT SHOCK

Editor, HOSPITAL MANAGEMENT: I have never had occasion to write you regarding any unusual news items, but wonders do occur even in the hospital field. I have in mind particularly an incident that occurred to me the other day and I thought it was worth mentioning to you.

About five years ago we were informed by a hospital that they could not pay any of their bills and naturally we wrote the account off our books. The other day I called on the superintendent of that hospital who gave me an order and began telling me about his institution. He informed me that in spite of the trying times he was paying off some of his old obligations and that we were in line to receive a check for our long forgotten account. I thought it was merely conversation, when, lo, and behold, on November 21 I received a check for \$81.60 in payment of this long forgotten account.

This payment was so unusual and the shock was so great especially at these times, and I thought it was worth mentioning to you. What do you think?

TED STERN.

COMMENTS INVITED

Editor, HOSPITAL MANAGEMENT: Sometime soon write us a little story in HOSPITAL MANAGEMENT as to proper way of arriving at the number of employees month by month. Don't mention my name, however, as having asked for it. Some employees work full time, some more or less

part time. Is such individual an "employee"? Or must they all be worked out on 8-hour-per-day basis?

Some student nurses get no cash allowance. Are they "employees"? In classifying employees, is "R.N.s," "students paid cash," "students paid no cash," and "other employees," a good classification?

Consider these things in your "write-up."

READER.

\$5.37, NOT \$6.91

Editor, HOSPITAL MANAGEMENT: We wish to make correction in the statement of 1929 and 1931 comparative report of the United Hospital Fund of New York as it appeared in your issue of November 15th. The per capita cost of The Bronx Hospital for the year 1931 was \$5.37 and not \$6.91 as printed in your publication. If you will review the comparative report of expenses and income you will notice that The Bronx Hospital was one of the two hospitals out of the 29 general hospitals of the United Hospital Fund which showed a decrease of expenditures with an increase of income for 1931 as compared with 1929.

We are enclosing copy of letter from the United Hospital Fund regarding this correction which they failed to make in the report they sent you.

WILLIAM B. SELTZER,
Superintendent, The Bronx Hospital,
Bronx, N. Y.

APPROVED BY A. C. S.

Editor, HOSPITAL MANAGEMENT: It may be of interest that the East Oakland Hospital, 90 beds, in the Fruitvale District, Oakland, has been awarded full approval of the American College of Surgeons. This has been very gratifying to us, as we have been endeavoring for two years to build up the hospital to meet the requirements of standardization. When Dr. Moots visited our hospital about three months ago, he expressed himself as being very happily surprised at the type of work that is being carried on here, and in recent communications from the College, Dr. MacEachern and Dr. Martin both mentioned the very satisfactory report that was rendered by Dr. Moots.

It has been the writer's privilege to be connected with this institution since August, 1930, as superintendent and it has been a task that has been truly enjoyable, for the employees and doctors have been most cooperative and have been responsible in a great measure for the successful working out of plans for standardization.

HARRY G. WILLIS,
President, East Oakland Hospital, Oakland, Calif.

"IMMATURE SUPERINTENDENTS"

Editor, HOSPITAL MANAGEMENT: In your November issue I am much interested to see that you have again given prominence to the drawback of "immature superintendents," and the pronounced recognition given this fact, by the A. C. S. Also, I was interested in noting that of the "Fourteen Conventions in a row," Mr. Behrens and I had attended eight, taking with us each time, student nurses or officials. Also, your page of letters to the editors contains a lot of inspiration.

MRS. P. W. BEHRENS,
Buckhannon, W. Va.

Modernization Offers Opportunity to Reduce Expences

The economies which can be accomplished by junking obsolete equipment and replacing it with devices which do the work not only better but at less expense, are well known to American industry, but they have not always been appreciated in the institutional field. Surprising savings can be made in this manner, and careful investigation along this line is one of the most important duties of the hospital executive. The information contained in the literature listed on this page is at your disposal free of charge. Requests for it, by number, will be promptly taken care of.

Anaesthetics

No. 350. "Why Use Gases as Anesthetics and Resuscitants?" A 32-page booklet from periodical and text literature on this subject. Published by Puritan Compressed Gas Corporation. 1232

No. 290. "Suggested precautions in the use of ether, ethylene and other anesthetics." Puritan Compressed Gas Corp. c30.

Cubicle Equipment

No. 337. "Privacy in the Modern Hospital" is the title of a valuable booklet on cubicle screening published by H. L. Judd Co. After outlining the problems involved in securing privacy for ward patients, the booklet works out concrete solutions for many problems. c32

Disinfectants

No. 342. A table showing the amount of Lysol disinfectant and water necessary to make solutions of various strength, together with a description of the correct solutions to use for various purposes in the hospital. Also a dilution chart for use in the laundry. Lehn & Fink, Inc. 532

Flooring

No. 334. "Resilient Floors," an interesting photograph album showing Sealex floors designed and laid in recent years. Also contains a description of the many types of Sealex floors. Congoleum-Nairn, Inc. 232

General Equipment, Furnishings and Supplies

No. 327. Booklet describing professional uniforms for nurses and others, published by Henry A. Dix & Sons Corp. b0

No. 284. "Ten Kinds of Baths." Cannon Mills, Inc. b0

No. 261. "Nurses' Apparel and Hospital Supplies," a 32-page catalog. Marvin-Neitzel Corp.

No. 341. "SnoWhite Tailored Uniforms," and "SnoWhite Tailored Uniforms for Student Nurses," two booklets describing the complete uniform line of Sno-White Garment Manufacturing Company. Each style is well illustrated and completely described. 532

No. 323. "Standard ready dressings and supplies for hospitals," a folder showing the styles, types and sizes of ready made products. Johnson & Johnson.

No. 328. "Curity Ready Made Dressings Manual," an interesting manual showing the complete line of ready made dressings, with descriptions of uses and other informative material. Lewis Mfg. Co. L31.

No. 351. The new Will Ross Catalog of hospital supplies for 1933. Handsomely printed on coated stock in several colors. 1232

No. 333. Numerous interesting booklets and pamphlets describing the therapeutic effects, the method of manufacture, and medical history behind many "Roche" drug products. Hoffmann-La Roche, Inc. 232

No. 336. "Cotton, Gauze and Adhesive Plaster—

Their Manufacture and Application in Surgery," an exceptional booklet of 96 pages. Published by Johnson & Johnson. c32

No. 339. "Kalmerid Germicidal Tablets," a pocket-size leaflet describing the composition, efficiency and uses of this new product. Davis & Geck, Inc. 432

No. 340. A complete series of pamphlets, many of which, such as "The Mystery of Sleep," "Why the Cat Unit?" and "When Chemists Turned from Gold to Drugs," are especially useful in teaching materia medica to student nurses. Available in any quantity. Hoffman-La Roche, Inc. 432

No. 314. "How to Obtain Maximum Service from Hypodermic Needles and Syringes," an interesting, pocket size manual on the selection of needles and syringes for each kind of service. Also contains practical information on how to sterilize, clean, and care for these instruments. Becton-Dickinson Company.

No. 332. Bulletin No. 260, describing the Powers thermostatic radiator valve, a self-operating regulator designed for vacuum or vapor steam heating systems. The Powers Regulator Co. 132

No. 348. Kenwood Mills, Albany, N. Y., have prepared a folder containing swatches in color of blankets and rugs, together with all necessary information concerning these hospital products. This folder is most useful for reference.

Kitchen and Food Service Equipment

No. 349. "Practical Planning for Hospital Food Service," a 62-page booklet published by the John Van Range Co., covering every detail of kitchen and food service planning and equipment. 1032.

No. 352. "Colt Autosan Dishwashing Machines," a compact 32-page booklet showing dishwashing machines of various sizes, accompanied by kitchen layouts in blueprint form indicating efficient arrangement of equipment. Published by Colt's Patent Firearms Manufacturing Company. 1232

No. 351. "Adobe Ware," a beautifully illustrated 12-page booklet describing the newest type of china for general and tray service. Onondaga Pottery Co. 1032.

No. 331. "Good Coffee," a monthly publication of interest to all quantity users of coffee. Published in newspaper style and containing many hints valuable in the preparation of coffee. Continental Coffee Co., Inc. 132

No. 300. "The Perfect Tray," by Helen E. Gilson, Onondaga Pottery Co. d0

No. 276. Modern Kitchens. A 70-page booklet. International Nickel Company. C30

No. 252. "Scientific Hospital Meal Distribution." Swartzbaugh Mfg. Co., Toledo, O.

Laundry Equipment and Supplies

No. 277. Laundry Owners' Year Book. International Nickel Company, Inc. C30

Sutures and Ligatures

No. 338. "The Bacteriological Control of D. & G. Sutures," an interesting pocket-size folder describing the various manufacturing processes of sutures. Davis & Geck, Inc. 432

No. 322. "Handbook on Ligatures and Sutures," 1931 edition. An interesting booklet on the history, preparation, handling and use of ligatures and sutures, completely revised. Johnson & Johnson.

Sterilizers, Stills

No. 234. "American Sterilizers and Disinfectors." Catalog. American Sterilizer Company, Erie, Pa.

No. 213. "Sterilizing Technique Series." Five booklets. Wilmot Castle Company.

What are *your* modernization plans for 1933?



THERE is no doubt but what the tendency is to modernize present facilities rather than to put up new buildings or to build extensive and expensive additions.

Bedside screening offers a simple, effective and economical method of modernizing your wards, semi-private rooms, treatment rooms, examination rooms, out-patient departments and similar places where complete and convenient privacy is essential.

Day's Cubicle Curtain Equipment aids the personnel in the performance of their duties—provides the advantages of private room atmosphere in semi-private rooms—makes

wards more private, more orderly, more livable—permits a saving in personnel — and results in increased bed hours.

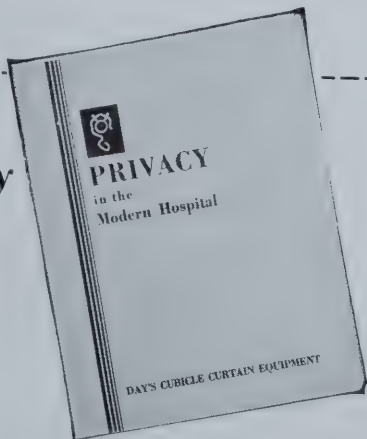
Our Engineering Department will gladly study your individual needs and submit a layout that will assure you of an efficient system of curtain screening—at a price comparable with any other type of screening. May we submit a quotation on your requirements to prove that bedside screening should be and can be an important part of your modernization plans for 1933?

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Please send me "Privacy in the Modern Hospital"—which explains how leading hospitals have solved the problem of suitable screening.

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Hospital

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H. M. -12-32

Lessons of '32 Conventions

ATTEENDANCE at meetings gives one a renewed perspective of the magnitude and requirements of the hospital field.

Educationally, meetings are in the nature of a short post-graduate course in hospital efficiency, methods of balancing budgets, practical economics and departmental organization and management.

One thing, at all meetings, which greatly interested the writer was the manner in which hospitals are adjusting themselves to the present difficult conditions.

Money is well invested which is used in attending different state and national association meetings.—C. S. PITCHER.



IN attending both national and state meetings, I feel that they have been extremely beneficial from the point of view of renewing acquaintances and discussing many hospital problems which, before we go to these meetings, we think belong only to ourselves.

At the national meeting, superintendents are permitted on one floor to view all the latest improvements in hospital equipment, and that, in itself, is a very big advantage.—T. T. MURRAY.



IHAVE had the privilege of attending some very interesting hospital meetings this year and have observed the progress of hospital administration despite the "depression."

We must acknowledge that the past two years have left their trace of "hard times" and in some institutions poverty has been just around the corner. Trustees and superintendents have struggled against the burden of debts contracted in the "good old days" when money came easy and went the same way. When unemployment increased rapidly, hospital executives began to realize the shrinkage in bed occupancy and inability to pay bills. The cost of operating the hospital has remained about the same.

With 50 to 60 per cent of the hospital beds vacant, most of them high-

er priced rooms, a heavy decrease in income soon brought the problem of how to budget income and expense. Some hospitals waited too long, hoping things would change for the better. The boards and superintendents were then faced with an entire change in policy in order to try to stem the tide. Some changes were very effective and others almost disastrous.

It required courage, ability and cooperation to face such a problem. The effort to keep pressing on was a big problem, but finally in many hospitals came the combined efforts of the board, superintendents, physicians, nurses and personnel which resulted in much good.

Some boards thought the superintendent was responsible for the decrease in business and the failure to collect bills. A change in administration was advocated. In most instances, the change was costly.

Much of the discouragement has passed away, many of the evils and mistakes of readjustment are things of the past, and as the smoke clears away we find that our hospital meetings were well attended and the visitors optimistic.

The hospital superintendent and board and staff members who regularly attend hospital meetings have been better prepared to meet conditions, as they were better informed. I think hospital meetings and conventions will be better attended than ever before as they have become more appreciated and the value gained by such contact and cooperation far outweighs the time and money needed.

The best and most successful hospitals are those whose executives and personnel attend hospital meetings and read hospital journals.—B. A. WILKES, M. D.



IAM pleased to answer your question, "What did you learn from attending meetings during 1932?" as follows:

1. I was pleased to observe that the hospital workers are eager to discover new truth, to discuss old truths, and to acquire any information that will possibly improve the service of their institutions.

The views which were expressed by discussants were varied and represented every phase of hospital administration. One inevitably learned that no one is doing a perfect job, but the best administrators are seeking light in order that they may do better, and those who are inexperienced could get help.

2. The obligation of the political units—city, county and state—to provide hospital service for their indigents was one of the most important subjects which the delegates had to consider. Unfortunately, nothing definite seemed to have eventuated from the discussion. It is impossible to believe that private philanthropy can continue to supply funds with which to do this fundamental work. The objects of support of private individuals are coming to be pretty sharply classified. Public funds are not available for character building institutions. They must be maintained by private contributions. The adequate care of the indigent sick is not an obligation of the private citizen, but of his government. The sick poor may be cared for in private institutions but the cost should be borne by governmental divisions. This does not mean, of course, that well-to-do men and women will not continue to provide funds for endowment and special purposes to private hospitals. It does mean that the cost of providing hospital service to those who are unable to pay for it in any community will be placed where it properly belongs and the institution which gives the service will be paid for it.

The credit of some institutions doubtless has been exhausted in these times because they have continued to give free service to the poor.

The deficits will have to be met some time and the future of these institutions may be greatly endangered.—C. S. WOODS, M. D.

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designed to encourage donations
and more generous co-operation from
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537 South Dearborn Street, Chicago.

Please tell me about the year's publicity service for hospitals
that will cost \$110 or less.

We understand that there is no obligation involved in this
request.

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City, State

AD-venturing

Probably no other fruit is more welcome to the average patient than is—pineapple. Now, food research shows that pineapple—canned—speeds digestion in stomach, of meals of which it is a part . . . is a potent aid in preventing acidosis, by contributing effectively to the alkalinity of the food . . . is rich in minerals, providing copper, iron, and manganese—well-known safeguards against nutritional anemia—and calcium and phosphorus in notable quantities . . . and is a splendid source of vitamins A, B, and C. Page 49.

* * *

As the result of recent reorganization, the John Van Range Company is now entirely independent of and unrelated to any other concern in the kitchen engineering and food service industry. The reorganization affects only the ownership and executive management. "Key men" in the old organization have become officers in the new; engineers, production operatives, sales and office personnel who have made this the leading service organization in its field are still with us. Page 52.

* * *

Since the advent of the Victor "Oil-Immersed" Shock Proof X-Ray Apparatus, a number of seemingly insurmountable problems in x-ray diagnosis have found solutions. With both the x-ray transformer and the x-ray tube immersed in oil and sealed within a grounded metal container, resulting in the complete elimination of all exposed high tension wires, the path was cleared for certain types of x-ray examination which the so-called "open type" equipment had always precluded. Second Cover.

* * *

The air conditioning unit is the "heart" of the plant—the ducts are the "circulatory system"—but the automatic temperature and humidity control is the "brain" which commands the whole installation. When the control apparatus is Johnson, dependability and accuracy are assured. Page 47.

* * *

Bay's Sanabans do not shrink after you sterilize them. Ordinary cellulose napkins do. Therein lies a big difference—as the picture shows. But it is only part of the difference. Bay's Sanabans when sterilized after forty-five minutes under fifteen pounds of steam pressure still remain uniform in shape and size. They retain their

softness and are free from dust. Page 1.

* * *

New B-D medical center needles of hyper-chrome (rust-resisting) steel, have a square, easily handled hub and improved point which makes for easy penetration and reduction of seepage. A low-priced rust-resisting needle. Page 65.

* * *

Radical improvements in the application of electricity to the heating of sterilizers are now announced by the American Sterilizer Company. The performance is now so reliable and accurate, the maintenance factors so much improved, that the use of electric power can no longer be classed as luxurious, but must be considered on a competitive basis with steam. Page 2.

* * *

This truly ideal suture, sterilized by heat in hermetically sealed glass tubes, offers obvious advantages over skin sutures in envelopes at no premium in price. It is of absolute sterility, is extremely flexible, and is unaffected by age or climate. Tubes may be boiled. Page 7.

* * *

Day after day—year in and year out—the nurses' army marches from eight to thirteen miles a day! That's no haphazard estimate; it is the actual showing of pedometers worn by hospital nurses while going about their ordinary day's work. No wonder, then, that the records of forty-five new hospitals show that linoleum is the leading resilient floor today. No wonder that nurses so quickly feel the difference after resilient Sealex Linoleum Floors are installed. Sealex Floors have just the right amount of "give" to conserve energy and good nature in the course of a nurse's long day's hike. Patients, too, welcome these noise-reducing, eye-pleasing Sealex Floors. Page 39.

* * *

In the last twenty years in America every so often some new form of anesthetic has been put on the market, sometimes with most startling claims. Most of them vanish as rapidly as they come, because they cannot stand the test of time. It was just about twenty years ago that nitrous oxide and oxygen first came into real use as a major anesthetic. Today, supplemented by ethylene and carbon dioxide gases, they are more largely consumed than ever before, and the consumption is constantly growing.

The use of these products has stood the test of time. Page 63.

* * *

Naturally, all alcohol is not alike—there are many kinds and grades—alcohol made from molasses is used for some purposes, alcohol made from grain is used for other purposes, and for the most exacting uses is made according to private specifications. Purity and clarity are necessary and should be uniform. A grade known by a definite brand name, or a specification alcohol, should be and can be uniform. Because sufficient care is taken Rossville alcohol is held to certain standards. It is uniform. Page 41.

* * *

It is our sincere wish that the bells of Yule-tide are ushering in for you a new era of happiness and prosperity. It is gratifying to find that there is still an appreciation of real values, and we are deeply grateful for the fact that an ever-increasing number of satisfied users bear witness to the efficiency and economy of Wyandotte Products. Page 16.

* * *

Look at your china—as your patients do. It is poor economy to continue to use chinaware after it has outlived its usefulness. It is not only a reflection on your institution, but it is a proved fact that people eat less when the china service is scratched, cracked, chipped or discolored. Page 57.

* * *

Olive oil to make skin charming, youthful! say beauty specialists. And in soap—more than 20,000 of them wholeheartedly recommend Palmolive—the one soap that tells you, shows you, its beauty ingredient. The test tube explains all. It shows you why women are sure of Palmolive—why more women use Palmolive than any other kind. It shows why your patients expect this famous beauty soap in your hospital. It is the reason more and more hospitals are finding Palmolive an investment in goodwill! Page 63.

* * *

Plaster room uncertainties—of personnel and product—are eliminated when you adopt Orthoplast Bandages, now used by Bellevue Hospital, New York, and many other large institutions. Orthoplast Bandages are uniformly made to give uniform results. Made with specially-refined plaster of Paris, pressed smoothly with scientific exactness into Red Cross surgical crinoline by machine. Serrated edges prevent raveling and tangling threads that hinder application. Complete saturated in less than a minute. Page 69.



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Season's Greetings

It is our sincere wish that the bells of Yule-tide are ushering in for you a new era of happiness and prosperity.

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HOSPITAL MANAGEMENT

A Practical Journal of Administration



Appointment System Saves Money, Time, Effort in O. P. D.

Patient, Doctor and Department Itself Well Served
by Orderly Assignment of Patients; Widespread
Use of System Offered as Proof of Its Advantages

By RAY M. AMBERG

Manager, Out-Patient Department, University of Minnesota Hospitals, Minneapolis

APPPOINTMENT systems for out-patient departments have been effectively functioning for a period now measured somewhere between ten and fifteen years. Early establishment of the plan of arranging for and assigning to patients definite days and hours for their return visits to dispensaries started experimentally in hospitals located in the eastern portion of the United States, and during these ten or fifteen years has spread to every corner of the country. Many of the original designers of appointment systems are with us at this meeting and it must be with gratification that these pioneers see and know the success of their effort to put out-patient departments on a systematic, orderly basis.

I think, that before one attempts to tell just what the advantages of an appointment system are, it might be well briefly to sketch the manner and features of general operation of such a system. The system in use at the University of Minnesota Hospitals is a fairly typical one and in most ways will present the average picture. The out-patient department at Minnesota has an average daily registration of slightly more than 300 patients. Essentially it is a low-priced pay clinic and offers its services principally to patients from the rural districts of the state and the suburbs of the Twin Cities in which there are no provisions for city or

county care. Applicants for service are interviewed during the morning hours from 8 until 11.

After the matter of residence and financial eligibility has been established, the patient is directed to the medical-admission service. The medical-admission service examines the patient, arranges for routine laboratory procedures and decides the assignment to the special clinic in which the patient's treatment and care are to center. The medical-admission service makes the arrangements to secure the first appointment for the patient in this clinic. From this new point the care of the patient now radiates—requests for consultation or treatment clear through this service and the responsibility for carefully planning the study, treatment, and return visits of the patient is here definitely assigned.

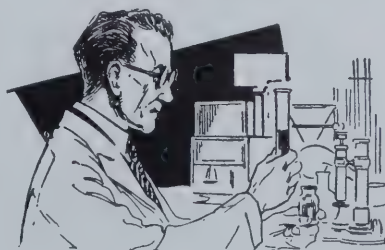
Under this plan, until the patient

has been discharged by the clinic, an appointment is given for the next return visit to the department and the patient knows that he has a specified day and hour for his next visit set up and reserved for him in the clinic.

Such a system as briefly described requires some hard and fast rules of management in order that its motion may be smooth. Some of the important features are: Impressing the patients that in order to be properly cared for they must keep their appointments and be on time; rigid control of staff attendance and punctuality; the distribution of arrival of patients over given periods; patient attendance regulated by estimated capacity; a unit record system and the centralization of the patients' care and treatment in a single clinic.

Now to proceed. The question really is: What special advantages are there in this type of service that designs by good management to eliminate the problem of accepting for treatment all who present themselves, within certain hours, irrespective of sufficient staff, time or space to properly care for them? Who derives benefits by this organization with a plan as against the one without a plan or system? Does the patient? Does the physician on the attending staff? Does the out-patient department administration?

First, let us consider the patient. An appointment system carries with it the responsibility of regulating the



— From a paper before out-patient section, 1932
A. H. A. convention.

number of cases in proportion to the available time, space and staff. The patient is assured that he will be taken care of and actually seen by a physician, that proper time has been allowed to study his case, and that he will be seen in an atmosphere conducive to good work. By centralization of the responsibility for his care in a single clinic his attendance is planned and consideration given to the time of his appointments and unnecessary trips and visits are eliminated. By arranging for a certain clock time for the patient's visit he may make his plans accordingly and long waits in the department, which frequently means loss of earnings for the father or hours away from the family for the mother, are reduced to the minimum, and anxious, annoying hours of bench warming which vex and exhaust the patient are eliminated. By giving patients the opportunity to see the same physician on successive visits the "family physician touch" is retained and the patient also has the benefit of a lack of conflicting opinions, diagnosis, recommendations and therapies.

For the physician also we can list several advantages. As has been previously stated, an appointment system implies the regulation of attendance to the known limits of staff, time and space. Contrast a department with a controlled attendance by appointment with that operating without. Uneven distribution of patient attendance will one day tax the resources of the clinic and the next day may find it almost without a patient to care for. With an appointment system the staff physician knows that his day consists of seeing a certain number of patients and he is able to plan and systematize his work and time to provide for sufficient care and study of the patient. Also in his study and handling of the patient the appointment system provides much of the necessary machinery for the return of the patient to the physician who is interested in the case from its problematic and educational value. Excessive demands on the physician are also eliminated and the swamped feeling that is entailed by the haste and rush of a big volume day in an uncontrolled clinic is never felt.

But to the administration of the out-patient department I think the greatest number of advantages accrue. During these times when demands on out-patient departments are taxing their economic resources to unthought-of limits the necessity of conserving staff, time, space and

equipment is of more than ordinary concern. Economic pressure is compelling the adoption and development of systems that guarantee efficiency and more adequate service from the funds in hand. The out-patient department whose administration fails to face the situation and continues to operate on the "catch as catch can" plan will be fortunate to survive for long. The appointment system offers a plan whereby the load of the department may be analyzed in all its phases. The relation of the day's attendance to all related units of the organization goes much beyond the clinic, the physician, and the patient. Regulation of attendance by appointment has much to do with the proper utilization of such necessary activities as the X-ray department, pharmacy, laboratories and record room.

The load of the record room is stabilized. Records for patients may be drawn and checked for laboratory, X-ray, and other reports on the day preceding the appointment. Records are sent to the clinic before the start of the clinic hour and thus much time of the patient and physician is also saved. Likewise, the X-ray department, clinical laboratories and pharmacy can make an estimate of what their day's load is to be and plan their work accordingly with the use of a minimum of personnel in order to operate economically. As in the cases of the departments previously mentioned, the social service department and the nursing service may also distribute their personnel to accommodate the known attendance and contribute to the savings of salaries caused by the elimination of peak day extra help.

In concluding it might be well to summarize the advantages that this type of organization for which I am speaking has over the other system or systems of conduct of an out-patient department.

Advantages to the patient:

Better service through efficient planning with a saving of time and long waits.

Better care through the centralization of care under one clinic or physician which assures more thoughtful diagnosis after plenty of time for study.

Better satisfaction through good handling by both the professional and non-professional staff.

Advantages to the physician: Systemization of his work with a resulting saving of time allowing for more and better study.

Opportunity to follow cases through by an assured return of the patient to his clinic.

Prevention of overloading by controlled attendance and finally the satisfaction that goes with good management and care of the patient.

Advantages to the administration:

Simplification of organization. Only a plan is required that arranges and dovetails the hours and duties of the attending staff to meet the demands and conditions of the patient.

Economic savings effected by arranging for the complete utilization of staff, laboratories, X-ray, pharmacy, etc., in the time allotted.

Satisfied patients and the feeling of a job well done.

Or, to summarize in a very few words, the appointment system offers to the patient, to the doctor, and to the out-patient department administration a plan containing all the essential points of good management with a minimum of effort, time and space expended.

Recent Changes

Harry E. Brown recently became superintendent of the Northwestern Hospital, Minneapolis, succeeding Mrs. Pearl Rexford, who had been superintendent for twelve years.

Jane Durham has been appointed superintendent of the Englewood Hospital, Englewood, N. J., succeeding Mary Elizabeth Lewis, who resigned after eleven years of service.

Edna H. Nelson, Superintendent, Ryburn Memorial Hospital, Ottawa, Ill., announces that Dr. Roswell T. Pettit has been appointed roentgenologist and pathologist. Dr. Pettit served two years as house officer at the Peter Bent Brigham Hospital, Boston; was assistant pathologist at the University of Graz, Austria. During the war he was with the laboratory service of the U. S. Army.

Madeline I. Lundgren recently was chosen superintendent of nurses at the Easton Hospital, Easton, Pa. Miss Lundgren is a graduate of the New Rochelle Hospital, New Rochelle, New York, and served as assistant superintendent of nurses at the Staten Island Hospital. Since April she has been assistant superintendent of nurses at the Easton Hospital.

\$10,000 BEQUEST

Wesley Memorial Hospital, Chicago, Paul H. Fesler, superintendent, recently received a \$10,000 bequest, without restrictions as to use, from the estate of Maria Webb.

Group Insurance, Training Urged By Medical Costs Committee

Government Hospitalization Curtailment Favored in Minority Report; Main Committee Recommends Sub-Nurses and Group Medical Practice

BASIC change in the system of providing medical care for the people of the United States is recommended in the report of the Committee on the Costs of Medical Care made public November 29 at the national conference on the Costs of Medical Care held at the Academy of Medicine, New York City. Asserting that our physical and mental health is the nation's greatest asset, the report, which has been adopted by a substantial majority of the committee, urges immediate steps to provide better medical care for the people of the United States, and to bring this about, outlines five recommendations. Prominently featured among the recommendations are group organization of medical service and group payment of the costs.

The five basic recommendations of the committee are:

1. That medical care be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel, centered around a hospital, and rendering home, office and hospital care.
2. That all basic public health services be extended until they are available to the entire population, according to its needs.
3. That the costs of medical care be placed on a group payment basis through the use of insurance, taxation, or both methods, without precluding the continuation of the individual fee basis for those who prefer it.
4. That a specific organization be formed in every community or state for the "study, evaluation, and coordination of medical service."
5. That the professional education of physicians, dentists, pharmacists and nurses be reoriented to accord more closely with present needs, and that education facilities be provided to train three new types of workers in the field of health, namely, nursing attendants, nurse-midwives, and trained hospital and clinical administrators.

The development in each city of one or more hospitals into a "Community Medical Center" is called the "keystone" of the committee's recommendations. These centers would provide complete medical services in return for weekly or monthly fees, with, when necessary, some supplementary support from tax funds. Professional procedures, according to

The accompanying is an official "release" from the Committee on the Costs of Medical Care, emphasizing certain features of the final report the committee made after five years' study. Much of the report is of special interest to hospital administrators, as well as to physicians and nurses, and hence the "release" is printed in full, except for brief excerpts from some of the previously published preliminary studies by members of the research staff of the committee.

the report, would be under the control of the physicians, dentists and other practitioners, and financial responsibility would rest with a board representing the public.

The personal relation between patient and practitioner would be carefully maintained in such centers, the committee states. Such organization, it asserts, would be fairer to practitioners than the present system, because it would provide them with higher average incomes and would give the largest rewards to those with the greatest experience and ability.

The recommendations in general, the committee stresses, provide for the development of existing machinery rather than the construction of entirely new organizations.

Based on an exhaustive five-year study of all major aspects of medical service in the United States and a careful consideration of European experience with health insurance, the report provides for the first time a scientific basis for communities throughout the country to attack the perplexing problem of providing adequate medical care for all persons at costs within their means. A document of 236 pages, it is to be published by the University of Chicago Press.

The conference at which the report was released was attended by leaders in all fields of medicine and

public health, by industrialists, representatives of labor, heads of women's organizations, educators, economists and other representatives of the general public.

The highlights of the 26 fact-finding studies of the Committee on the Costs of Medical Care were presented to the conference during the morning session by members of the committee and the research staff.

The recommendations of the committee were presented at the opening of the afternoon session by Dr. C. E. A. Winslow, vice-chairman of the committee and professor of public health, Yale University. The minority viewpoints were presented by Dr. Nathan B. Van Etten, New York. Among the speakers at the afternoon session who discussed present and future significance of the committee's findings and recommendations were Dr. Lewellys F. Barker, Baltimore, a member of the committee, who spoke from the physician's point of view, and President Livingston Farrand, Cornell University, who spoke from the public health point of view.

The speakers at the concluding session of the conference at night were Dr. Ray Lyman Wilbur, chairman of the committee, and former president of the American Medical Association, who spoke on "The High Points in the Committee's Recommendations"; Dr. John A. Hartwell, professor of surgery, Cornell University Medical College, and past-president of the New York Academy of Medicine, who discussed "The New Outlook for Medicine"; and President James R. Angell, Yale University, whose subject was "The Future and the People's Health."

Among other conference members were: Dr. R. H. Bishop, Jr., Cleveland; Dr. Philip King Brown, chief physician, Southern Pacific Railroad, San Francisco; Dr. W. C. Davison, dean and professor, pediatrics, Duke University School of Medicine, Durham, N. C.; Paul Fesler, past president, American Hospital Association, Chicago; Paul U. Kellogg, editor, *The Survey*; Dr. Frederick P. Koppel, president, Carnegie Corporation;

John A. Kingsbury, secretary, Milbank Memorial Fund.

Dr. Dean Lewis, surgeon-in-chief, Johns Hopkins Hospital, and president-elect, American Medical Association, Baltimore; Dr. Adolf Meyer, professor of psychiatry and director of the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital; Dr. A. L. Midgley, secretary, American College of Dentists, Providence; Albert C. Milbank, president, Milbank Memorial Fund; Anne Morgan, president, American Woman's Association, New York; W. J. Norton, secretary, Detroit Community Fund, Detroit; Fred C. W. Parker, secretary, Kiwanis International, Chicago; Mrs. John F. Sippel, ex-president, General Federation of Women's Clubs, Baltimore.

Dr. W. H. Welch, president, board of directors, Rockefeller Institute for Medical Research, Baltimore; Dr. Horace J. Whitacre, president, Washington State Medical Society, Tacoma; Dr. Linsly R. Williams, managing director, New York Academy of Medicine, New York; Dr. M. C. Winternitz, dean, school of medicine, Yale University, and Leo Wolman, professor of economics, Columbia University.

The report represents the result of five years' study by the Committee on the Costs of Medical Care—an unofficial organization composed of 48 physicians, public health officers, economists, and representatives of various institutions and of the general public—under the chairmanship of Dr. Wilbur.

Sixteen of the 24 doctors of medicine on the committee, seven of the 11 members engaged in other forms of medical and public health work, and 12 of the 13 economists and representatives of the public support the committee's five recommendations.

In the introduction to the report, Dr. Wilbur states:

"When the committee was organized, an effort was deliberately made to secure as members persons representing all points of view on the problems under consideration. There are two important results of this policy. First, all interests and points of view, it is believed, have been adequately considered in the formulation of the committee's recommendations. Second, there have been two small minority groups which, not able conscientiously to subscribe to the views of the majority, have submitted minority reports; and two other members have prepared personal dissenting statements."

The principal minority report, signed by nine members, has seven recommendations as follows:

1. That government competition in the practice of medicine be discontinued and that its activities be restricted entirely to certain types of service.

2. That government care of the in-

digent be expanded with the ultimate object of relieving the medical profession of this burden.

3. That coordination of medical service be considered an important function for local communities.

4. That united attempts be made to restore the general practitioner to the central place in medical practice.

5. That the corporate (i.e., organized) practice of medicine be vigorously and persistently opposed as wasteful, inimical to high quality, or productive of unfair exploitation of the medical profession.

6. That careful trial be given methods which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice.

7. That state or county medical societies develop plans for medical care.

In a separate personal statement, Professor Walton H. Hamilton of Yale University presents a scholarly outline of the evolutionary background of the problem of medical care and suggests that it be solved by a scheme of medical organization paralleling the type of organization now in vogue in universities. Two dentists on the committee present a second joint minority report supporting in general the recommendations of the majority but criticizing certain aspects of them.

In presenting this final report, which represents five years of intensive work by the committee, and its large research staff, Secretary Wilbur said:

"The problem of delivering adequate, scientific medical care to all the people, rich and poor, at costs which can be reasonably met by them in their respective stations in life, is vital to the American people. The Committee on the Costs of Medical Care, formed in 1927, an unofficial organization composed of physicians, public health officers, economists, and representatives of various institutions and of the general public, has presented ways of meeting this problem. It has completed 26 studies. The committee has been supported by eight foundations and two other organizations—the Carnegie Corporation, the Josiah Macy, Jr., Foundation, the Milbank Memorial Fund, the New York Foundation, the Rockefeller Foundation, the Julius Rosenwald Fund, the Russell Sage Foundation, the Twentieth Century Fund, the Social Science Research Council, and the Vermont Commission on Country Life.

"The American Medical Association, the American Dental Association, the Metropolitan Life Insurance Company, the National Bureau of Economic Research, and the National Tuberculosis Association have conducted supplementary studies which have been of great value to the committee's program of study. The United States Public Health Service gave valuable assistance in the tabulation of an immense amount of statistical data gathered in connection with the committee's study of the incidence and costs of sickness among families. Finally, state and local departments of health, visiting nurse associations, and other organizations and individuals have cooperated most generously in the field work of the committee's vari-

ous studies. The work performed without cost to the committee by collaborating agencies and the various organizations and individuals who have assisted in the field work would otherwise have required the expenditures of a great many thousands of dollars."

Dr. Wilbur expressed the hope that when the present committee goes out of existence January 1, 1933, some other organization may be formed for the purpose of promoting further research in the field of medical economics. It is also hoped, he stated, that a continuing organization may immediately be formed to promote experimentation and demonstrations in local communities along lines proposed in the committee's recommendations.

PRESENT "DEFICIENCIES"

The report outlines the present situation in the provision of medical care, basing this summation on the findings in its 26 extensive studies into all aspects of the problem.

As a result of this survey into existing conditions, the report then lists the following "deficiencies in the provision of medical service which seem to be within the power of the American people—professional and lay, separately or together—to overcome at the present state of medical knowledge":

1. The people need a substantially larger volume of scientific medical service than they now utilize. This is particularly true of persons with small incomes. In spite of the large volume of free work done by hospitals, health departments, and individual practitioners, and in spite of the sliding scale of charges, it appears that each year nearly one-half of the individuals in the lowest income group receive no professional medical or dental attention of any kind, curative or preventive.

2. Modern public health services need to be extended to a far greater percentage of the people, particularly in rural areas, towns, and small cities.

3. There is need for a geographical distribution of practitioners and agencies which more closely approximates the medical requirements of the people.

4. Current expenditures for medical care, in rural and semi-rural areas, are insufficient to insure even approximately adequate service, to support necessary facilities, or to provide satisfactory remuneration to the practitioners.

5. Many practitioners, particularly well-trained recent graduates, should have opportunities to earn larger net incomes than they now receive. Incomes of general practitioners and of specialists should be more nearly equal than at present. The opportunity and incentive for "fee-splitting" should be removed.

6. Better control over the quality of medical service is needed, and opportunities should be provided for improving quality as rapidly in the future as it has been improved in the past. Improvement of the quality of service would include: elimination of practice by unqualified "cult" practitioners; control over practice of secondary practitioners (like midwives,

Recommendations of the Committee on Costs of Medical Care

I

The Committee recommends that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office, and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician.

II

The Committee recommends the extension of all basic public health services—whether provided by governmental or non-governmental agencies—so that they will be available to the entire population according to its needs. Primarily this extension requires increased financial support for official health departments and full-time trained health officers and members of their staffs whose tenure is dependent only upon professional and administrative competence.

III

The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods. This is not meant to preclude the continuation of medical service provided on an individual fee basis for those who prefer the present method. Cash benefits, i. e., compensation for wage-loss due to illness, if and when provided, should be separate and distinct from medical services.

IV

The Committee recommends that the study, evaluation, and coordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention.

V

The Committee makes the following recommendations in the field of professional education:

(A) That the training of physicians give increasing emphasis to the teaching of health and the prevention of disease; that more effective efforts be made to provide trained health officers; that the social aspects of medical practice be given greater attention; that specialties be restricted to those specially qualified; and that post-graduate educational opportunities be increased;

(B) That dental students be given a broader educational background;

(C) That pharmaceutical education place more stress on the pharmacist's responsibilities and opportunities for public service;

(D) That nursing education be thoroughly remolded to provide well-educated and well-qualified registered nurses;

(E) That less thoroughly trained but competent nursing aides and attendants be provided;

(F) That adequate training for nurse-midwives be provided; and

(G) That opportunities be offered for the systematic training of hospital and clinic administrators.

15 Years Ago—THIS MONTH—10 Years Ago

From "Hospital Management," December 15, 1917

American College of Surgeons prepares hospital data sheet before drawing up minimum standards for hospitals.

Council on National Defense urges hospitals to train more nurses, but not to attempt short courses in nursing.

Nineteen "reconstruction hospitals" planned by army in populous centers.

Blanche M. Fuller becomes superintendent of Methodist Hospital, Omaha, Neb., after five years as assistant superintendent of Christ Hospital, Cincinnati.

Dr. E. H. Collins carries on as acting superintendent of Grace Hospital, Detroit, while Dr. W. L. Babcock, director, is "somewhere in France."

From "Hospital Management," December 15, 1922

LaCrosse, Wis., Lutheran Hospital awarded verdict in suit brought by several physicians who were dropped from the hospital staff.

Dr. J. L. McElroy, after service with Hoover organization in Russia and elsewhere, becomes assistant superintendent of City and County Hospital, St. Paul.

Hospital executives of western Canada hold meeting in Winnipeg. Dr. George F. Stephens, Winnipeg General Hospital, presides.

chiroprodists, and optometrists); restriction of practice of specialties to those with special training and ability; more opportunity for post-graduate study for physicians, particularly rural practitioners; more opportunity for physicians to exchange experiences and to assist each other; better control, through supervision and further education, over the work of certain physicians and dentists who even though regularly licensed are not competent for many functions.

7. There should be more effective control over the number and type of practitioners trained, and their training should be adjusted to prepare them to serve the "true" needs of the people.

8. There is a need for reduction of waste in many directions, such as the money spent on unnecessary medication, on services of poorly qualified or utterly unqualified "cultists," and wastes due to idle time of practitioners, high "overhead" of private medical and dental practice, unused hospital accommodations, and the sending of patients from place to place for medical service.

9. There is need for some plan whereby the unequal and sometimes crushing burden of medical expenses can be distributed. The prevailing methods of purchasing medical care led to unwise and undirected expenditures, to unequal and unpredictable financial burdens for the individual and the family, to neglect of health and of illness, to inadequate expenditures for medical care, and often to inequable remuneration of practitioners.

ESSENTIALS OF SATISFACTORY PROGRAM

The following basic essentials are laid down in the report for consideration in the formulation of a plan for the provision of medical service:

1. The plan must safeguard the quality of medical service and preserve the essential personal relation between patient and physician.

2. It must provide for the future development of preventive and curative services in such kinds and amounts as will meet the needs of substantially all the people and not merely their present effective demands.

3. It must provide services on financial terms which the people can and will meet,

without undue hardship, either through individual or collective resources.

4. The program must include not only medical care of the individual and the family, but also a well-organized and adequately-supported public health program that will apply all existing knowledge to the prevention of disease and permeate all medical practice with the concept of prevention.

5. It should include provisions for assisting and guiding patients in the selection of competent practitioners and suitable facilities for medical care.

6. It must provide adequate and assured payment to the individuals and agencies furnishing the care. That this could be provided by comparatively small individual payments from those receiving such care is indicated in another part of the report, in which it is estimated that all needed medical care of the kind customarily purchased individually could be provided, excluding capital charges, for from \$20 to \$40 per capita per annum, which equals 40 to 80 cents per week. This estimate is based upon the actual experience of various organizations that are now providing complete or nearly complete service for weekly or monthly fees or without direct charge to the beneficiary.

Lines of Approach Indicated

After a discussion of each of the six foregoing "essentials" the report

specifies the following three "major lines of approach" in obtaining a satisfactory medical service which will meet these essentials:

1. The development of types of organized or group practice that will more effectively and economically meet the community's medical needs.

2. The distribution, over a period of time and over a group of families or individuals, of the costs of service.

3. Provision for the planning and coordination, on a local and regional basis, of all health and medical services.

Among other data included in the report is a discussion of the kinds of organization and administration that are deemed most likely to translate its objectives into action. This is followed by a resume of the most significant plans and experiments now under way in which the advantages and disadvantages of each are briefly summarized.

The report then considers the five recommendations outlined above in detail, and this is followed by a chapter pointing out the need for action and suggesting some practical immediate steps.

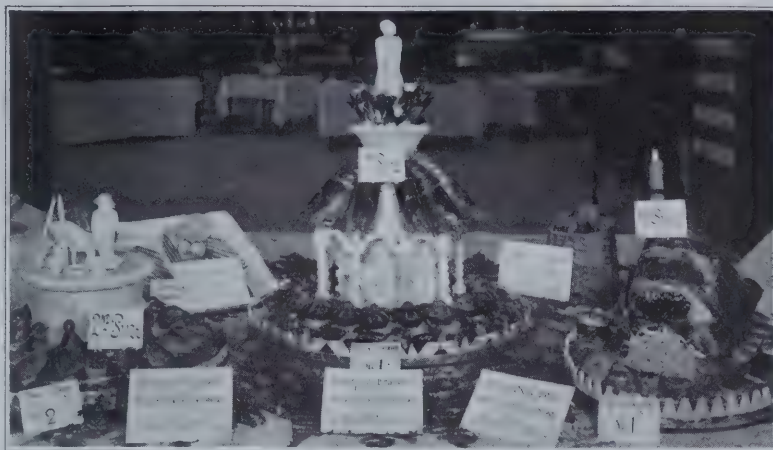


MRS. SEXTON DEAD

The many friends of Sherman J. Sexton, president of John Sexton & Company, Chicago and Brooklyn, will be shocked to learn of the recent death of his wife, Mrs. Alice C. Sexton. Mrs. Sexton was the daughter of the late William J. Conners, Buffalo, N. Y., newspaper publisher, industrialist and lake shipping operator, and besides her husband she is survived by three children, a brother and three sisters.

SUPERINTENDENT KILLED

Rev. Theo. Young, superintendent of the Greeley Hospital, Greeley, Colorado, died as the result of injuries suffered in an automobile accident en route to the recent Colorado Hospital Association meeting.



Can Hospital Chefs and Cooks Cook?

“CAN hospital chefs and cooks cook?”

Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, was so confident that they can that he had no hesitancy in entering representatives of his institution in the second salon of culinary art at the Palmer House, Chicago, November 28-December 3, and Mr. Bacon's confidence was justified by the award to his hospital of a number of prizes, including two firsts.

The salon of culinary art is sponsored by the Chefs of Cuisine Association of Chicago and attracts chefs and cooks from leading clubs and hotels. According to some of the officers of the association, the entry of the Presbyterian representatives and exhibits was set a precedent, hospitals

never before having entered in such a contest.

Leading chefs of Chicago formed the committee on awards and the fact that Presbyterian Hospital won first prize in events participated in by men who have a national and international reputation in their fields not only is gratifying to Presbyterian Hospital, but it also should be a source of pleasure to all who are desirous of combatting the impression that standards of food in hospitals are not high.

The entry of exhibits from Presbyterian Hospital, with the approval and co-operation of Mr. Bacon, was arranged by A. W. King and M. Gamero who for some time past have been in charge of the reorganizing of methods in the kitchen of Presbyterian Hospital. Erich Bode, chef,

and Fred Moser, pastry chef, spent a great deal of time preparing the hospital exhibits.

The awards won by the hospital included:

First prize, English roast beef, buffet style, Erich Bode, chef.

First prize, coffee cakes and Danish pastry, Fred Moser, pastry chef.

Second prize, Pastillage and artistic decoration, illuminated monument, with spring fountain, Mr. Moser.

Second prize, poultry dish, Mr. Bode.

Second prize, lobster en Bellevue Bristol, Mr. Bode.

Second prize, competition in hot dishes.

Honorable mention, cream slices Napolitaine, petit fours, assorted French pastry.

Isolation Technique in Mind as Building Was Planned

Separation of Cribs and Beds by Permanent Partitions, and Provision of Adequate Scrub-up Bowls
Features of New Flat New Floating Hospital Unit

By WILLIAM A. RILEY, A. I. A.

Edward F. Stevens & Associates, Architects, Boston, Mass.

THE new Floating Hospital building, called the Jackson Memorial Building, at the corner of Ash and Nassau Streets, Boston, has recently been dedicated and opened as a free hospital for sick babies and children.

The early history of the Boston Floating Hospital is well known throughout Boston up to the time the hospital boat was burned in 1927.

In 1931 the trustees decided to abandon the summer work on the boat for the sick children of Boston and to erect a permanent home adjacent to the Boston Dispensary and Tufts College Center Building. Through the generosity of Henry Clay Jackson and Paul Wylde Jackson, the erection of this \$200,000 modern hospital building was accomplished.

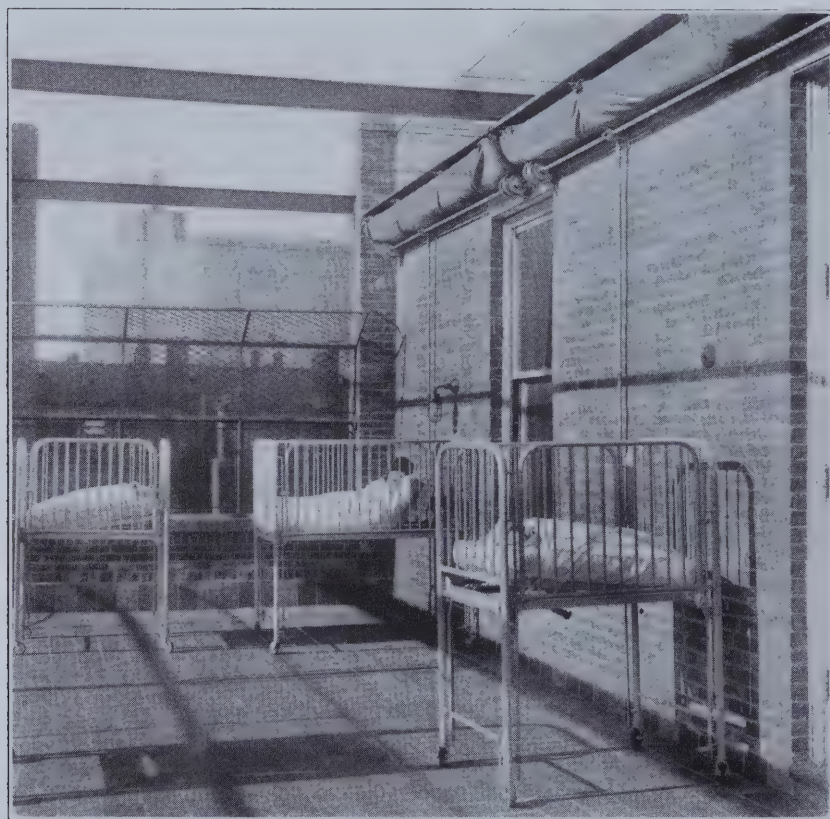
This new hospital contains 40 beds

for babies and children under twelve years of age for service throughout the year. The reason for placing this building adjacent to the Boston Dispensary was to enable the two institutions to share in the use of X-ray facilities, laboratory equipment, operating rooms, and plant operation.

The building is of Colonial design, with four stories and basement, built of sand-struck brick with limestone trim. The design is plain and economical, with a dignified and appropriate entrance in limestone with a terra cotta medallion, showing a mother and child, placed over the entrance. On the south side and across the entire end of the building on the fourth floor has been designed a "hurricane deck," duplicating the upper deck of the hospital boat, for sun baths. This hurricane deck has a sunny outlook above most of the surrounding structures. It has a canvas roof for shade for the summer time and will be the "Hurry up and get well" quarters for the children patients.

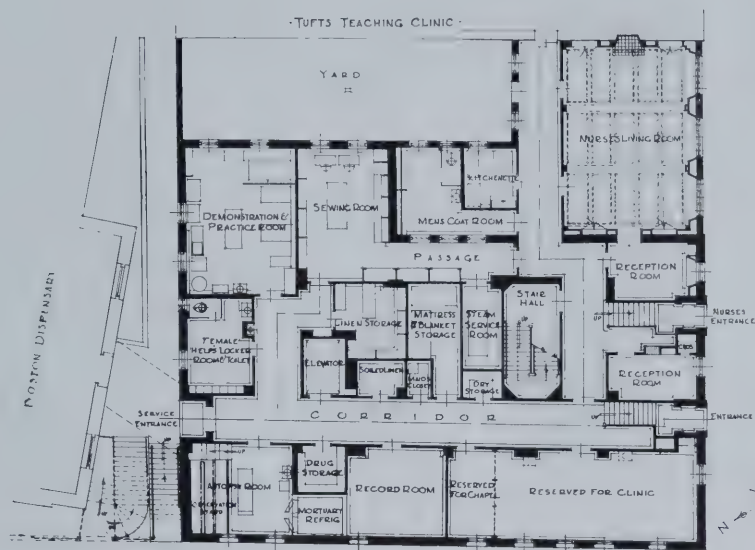
In the basement are the teaching and practice room, the sewing room, the storage room for linens and hospital supplies, and a clinic for research purposes in connection with the hospital for children. Off the passageway to the Center Building there is a large living room and two small reception rooms for the use of nurses. The living room is about 20 by 30 feet, panelled in chestnut and with beamed ceiling, with library and fireplace. Here the hospital atmosphere is lacking as this room was designed for use in connection with the nurses' quarters in the adjacent building, which also provides dining rooms, kitchen and laundry and a central plant for the entire building group.

The first floor of the Jackson Memorial Building is the administrative and admitting floor of the hos-



"Across the entire end of the building on the fourth floor has been designated a 'hurricane deck,' duplicating the upper deck of the hospital boat, for sun baths." Note the awning equipment.

Three Floors of the Jackson Memorial Building



The ground floor



The first floor



The third floor



"In the wards each bed or crib is separated from its neighbor by glazed partition. In every ward and private room scrub-up bowls, with elbow-acting valves are provided."

pital and contains a waiting room, doctors' examination rooms, board room with offices connected, and offices of the superintendent and doctors. The staff and board rooms are connected by a small serving room where refreshments are served for board meetings, visiting doctors, etc.

The second floor provides for the care of children from birth to five year of age and contains a four-bed ward, two nine-bed wards, a three-bed premature ward and two quiet rooms. There is also a six-bed nurses' infirmary which can be converted into a nine-bed infants' ward. Here also is the modern milk laboratory, with bottle sterilizer, lavatories and electric refrigerators, for the preparation of milk formulas.

The third floor is for the care of children from six to twelve years, the upper limit of age. This floor contains one six-bed, one five-bed, two four-bed wards, two quiet rooms, a diet kitchen, and like the second floor, the utility and wash rooms, as well as a modern elevator. A feature of this floor is the Calvin A. Richards Ward for tonsil and adenoid cases.

The wards and rooms are so planned that absolute isolation technique can be carried out. In the wards each bed or crib is separated from its neighbor by glazed partitions and no nurse or doctor goes from the bedside of one patient to that of another without a thorough

scrubbing up and change of gown. The custom of wearing the operating room mask when attending the children is carried out. Visitors allowed to enter the wards must don a special gown which covers not only the body, but the hands as well.

In every ward and private room



An attractive glazed terra cotta medallion, "Mother and Child," surmounts the entrance to the Jackson Memorial Building.

This article on the Jackson Memorial Building of the Boston Floating Hospital, one of the units of the New England Medical Center, will be followed in an early issue by a description of the Center Building, which provides service and housing facilities for the Medical Center as well as additional clinic space for the Boston Dispensary. The article will be written by Frank E. Wing, Director of the Boston Dispensary, who will also describe the manner in which the Medical Center functions for the benefit of its affiliated institutions, the Boston Dispensary, the Boston Floating Hospital and the Tufts College Medical School.

scrub-up bowls with elbow-acting valves are provided.

In addition to the hurricane deck, the fourth floor has a large solarium with ultra violet ray glass for heliotherapy treatment and a large playroom equipped with all sorts of toys for convalescing children. There is also a finished room to which the children's infirmary may be transferred from the second floor, with space for two future large wards. When funds permit, this space will be utilized to enlarge the capacity of the hospital to sixty beds.

The completeness of the equipment, laboratories and kitchen is in accordance with the latest improvements in child care. All wards have glazed partitions between every two beds, with ample room for teaching facilities.

NURSING LUNCHEON

The Central Council for Nursing Education will hold a luncheon meeting on February 14 at the Palmer House, Chicago, immediately following the joint session (devoted to Nursing) of the Council on Medical Education and Hospitals of the American Medical Association, and the American Conference on Hospital Service. Dr. Winford H. Smith, director, Johns Hopkins Hospital, Baltimore, will speak on "Future Trends in Nursing."

50 YEARS OF SERVICE

St. Mary's Hospital, Brooklyn, celebrated its fiftieth anniversary this month, having been opened in December, 1882. A gold ball at the Waldorf-Astoria Hotel, New York City, was the principal feature of the celebration, attracting 3,000, including many prominent citizens who witnessed an unusually brilliant pageant. Bishop Thomas E. Molloy, president of the hospital, opened the affair. The ballroom was done in black and gold, and it was hoped to realize \$10,000 for the free service of the hospital through the affair.

"The A. C. S. Recognizes Able Superintendents"

John M. Smith, director, Hahnemann Hospital, Philadelphia, president, Hospital Association of Pennsylvania—"The article entitled 'Importance of Good Executive Recognized by A. C. S.' is very interesting and timely and a great deal of good can come from it. The step which the American College of Surgeons has taken is one of very great importance. The writer has personal knowledge of several hospitals where thoroughly experienced and competent superintendents have been replaced by persons with no experience whatever. Usually the new superintendent is a member of the board of trustees. Recently we were requested to recommend a superintendent for a hospital from which a very competent person had resigned. The trustee stated that it was a great pity that such a competent superintendent was leaving them. Within a few days an equally competent superintendent was sent to see the board and was told that it had been decided to place one of the trustees in charge. The trustee placed in charge had retired from business on account of age a year or so ago and knows nothing whatever about hospital administration.

"This is a very deplorable state of affairs when it is remembered that hospitals deal with human beings in distress and that an administrator has a great deal to do with the efficiency of the treatment because it is his duty to furnish all of the service the physicians order. The reason a hospital is a better place than home for a serious illness is that the hospital has the technical apparatus and the trained personnel necessary to use it in a way that will promote recovery. This apparatus and personnel are hardly possible without an experienced administrator.

"During the past 15 years several serious attempts have been made by thoroughly able groups of people to establish and maintain college or university departments for training administrators. It is unfortunate that these courses have been withdrawn usually because of a lack of students. To the writer's knowledge there is no such course in existence in North America today. In consideration of this a tremendous amount of good can be done by the American College of Surgeons if it will continue actively its campaign in favor of better hospital management, which necessarily means better administrators.

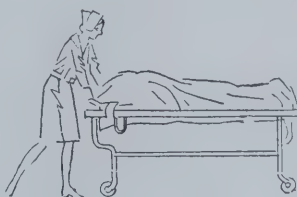
Here are comments on the article and editorial in the last issue, based on the fact that in its 1932 report on Hospital Standardization, the American College of Surgeons stated for the first time that approval of some hospitals had been withheld until immature superintendents had proved their ability. Other comments are to be found in Letters to the Editor, page 14; others will be printed later.

We congratulate that association and your magazine."

John R. Mannix, assistant director, University Hospital, Cleveland; executive secretary, Ohio Hospital Association—"The action of the American College of Surgeons in withholding approved rating from certain hospitals until the superintendent has proved his or her ability is no doubt a step forward and will probably receive the support of hospital administrators and trustees throughout the country.

"However, before this matter is carried any further, it seems necessary and desirable to set down minimum standards for hospital superintendents before we decide whether a hospital superintendent is qualified. There has been a great deal of discussion for many years regarding the setting up of such qualifications, and there is probably nothing which would so benefit hospital administrators as the establishment of a set of qualifications for their profession. The trustees of the American Hospital Association should undertake to set up a schedule of qualifications for hospital administrators, and no doubt the American College of Surgeons will be glad to accept their recommendations.

"HOSPITAL MANAGEMENT can be of service to the hospital field by emphasizing the importance of action along this line."



E. E. King, superintendent, Missouri Baptist Hospital, St. Louis; president, Missouri Hospital Association—"The American College of Surgeons has struck another note which I feel sure will ring clear and loud enough to be heard throughout our land when they have spoken for experienced hospital administrators.

"The College has done a great work through its program of Hospital Standardization. It has taken the hospitals, like the father his son, to the woodshed. It admonished them to do things which were at the time somewhat obnoxious. The College did not use the cruel, harsh strap, but pointed the way, encouraged and set for the hospitals higher and higher standards, which have resulted in blessing and benefits to the patients, better facilities for the doctors, and real constructive help for the hospitals.

"Like the boy from the woodshed, now grown up, hospitals are everywhere ready to praise the American College of Surgeons for the lessons and helps they have given. So it will be with their efforts in the field of hospital administrators.

"Avoidable mistakes are made, money wasted, and sometimes a patient deprived of the best chance to get well by the errors of the inexperienced administrator.

"The new administrator in the hospital field often feels at the end of his first year that he has solved about all the problems, by the third year he begins to understand he doesn't know very much, and by the fifteenth year he is learning something new every day. The American College of Surgeons can help the administrator, the hospital, the doctor and the patient by a program for experienced administrators."

EMERGENCY RELIEF

A group of Chicago hospitals are receiving \$3.75 per patient day and 90 cents per outpatient visit for caring for patients referred to them through agencies affiliated with or endorsed by the emergency relief organization. Some of the larger hospitals are allotted 25 beds for such patients. The outpatient allowance is limited to \$500 for any one month. In speaking of the hospital allotment, one man in charge of one of the larger hospitals explained that the hospitals entered into this agreement in full realization that the community was faced with an emergency and that the hospitals wanted to do their part in meeting the situation. It was explained to the relief organization that the patient day allowance did not come near covering the cost of the service rendered by the hospitals.

Two Sacramento Hospitals Join in Hospital Insurance

More Than 600 Memberships Sold in Less Than Six Months in Program of Special Interest to Hospitals in Communities With Few Institutions; Here Are Details of Plan

By R. D. BRISBANE

Superintendent, Sutter Hospital, Sacramento, Calif.

HOSPITAL MANAGEMENT's article on the Baylor University Hospital plan of periodic payments for illness was the inspiration for a somewhat similar development in our own community.

About the first of 1932, the board of directors of Sutter Hospital gave permission thoroughly to investigate the insurance method of hospitalization. While this was being done, a man with eight years' experience in the health and accident field suggested that both the Sisters Hospital and the Sutter Hospital join together in the move. This was done, and the final draft of the constitution and by-laws was ratified by the two hospitals, by the nurses' association, and tacit consent given by the medical and dental societies pending a formal meeting.

Three attorneys representing the main interests involved carefully went over each feature of the organization, and the advice of many of the medical fraternity was obtained before final adoption. Therefore, we felt that as much care as possible was used in its construction.

The Sacramento Plan differs radically from others in one point. In all other places either the hospital is paid the dues directly or a commercial organization does the collecting and remunerates the hospital in one form or another. We believed that the public would feel much better toward a method that would allow them to have all the benefit possible, and experience has proved our surmise correct, for there has been no sales resistance to overcome when employers or individuals found that the association formed was mutual, non-profit, and that all dues went into a common fund, the hospitals only receiving payment when any member of the association becomes ill.

In this manner, a reserve can be built up that will tend to not only reduce dues, but provide wider lati-

"The Sacramento plan" is a phrase that has come into use in discussions of group hospital insurance programs. Sacramento has two approved hospitals and they have joined in a plan to provide service to members of employed groups. Here is a detailed description of the plan, with a copy of the by-laws of the association to which members subscribe. It is to be noted that some 600 memberships are effective, although the plan is not yet six months old.

tude of care. In our community at least, it would have been nearly impossible to have sold anything of this kind had the dues been paid directly to either hospital or through a commercial organization.

The largest firms of the city, banks and other corporations who are unalterably opposed to any solicitation of their employees, have endorsed the idea through their managers or proprietors and given permission to personally solicit employees during working hours. This feature alone we believe is very worth while and places this form of insurance on the highest plane possible.



Dentists' and nurses' societies were asked to join with the physicians and hospitals because of their professional standing in the community. A representative of each of these organizations constitutes the governing committee and has proved very satisfactory in drawing the various interests together for the common good.

In promotion, the writer has gone with the executive secretary of the association to all the employers of the various firms, introduced the plan, and asked permission to speak at the next meeting of the employees. Two "contact" men have then followed and worked through the firm individually, forming groups of five or more wherever possible, in which case the membership fee of one dollar is waived and the dues made one dollar each month on payroll deduction basis, or quarterly if paid by individuals.

Much good has been accomplished indirectly already, a favorable reaction among the public resulting because of their knowledge that the professional groups of the city had started such a movement; and financially a benefit because our own organization has kept out two commercial hospital corporations that were ready to step in and get members for profit to themselves, with the money going outside Sacramento.

Physicians are pleased with the plan because every member of the association can have his own physician, and when the hospital bill is paid, the doctor is much more likely to receive something for his own services.

Until the new organization has grown to better proportions, a room is being given in one of the hospitals for an office in order to keep down overhead. The executive secretary is the only one employed thus far on a salary. His experience in health and accident insurance, as previously

mentioned, has been of considerable benefit and has saved us some of the errors that await such a plan.

We believe there is every reason to say that the association is a success thus far and has every promise of becoming a very solid part of the community. Not quite four months' effort has been put into the project and the membership is running above six hundred as this is written, with promise of a thousand members in another three months, at which time it will be fully self-supporting.

Ten claims have been handled already, with the very satisfactory result that the beneficiaries immediately go out and get more members. Circulars with an attached application blank are being given out to

each outgoing guest from the hospitals and all visitors whom we can meet.

Details are much the same as in other plans, full constitution and by-laws being given in the accompanying paragraphs.

We shall be glad to answer any inquiries if other communities or hospitals desire to organize similar associations, for we believe it is a long step in the right direction toward lowering the cost of hospitalization in the same manner as all unusual expense for the hazards of life or business is met, and we have no patent or copyright on the idea for we believe it is too good to be kept to ourselves or sold at the expense of the public.

Here Are Some of the Features of Sacramento Plan

TO meet all objections, and to avoid incorporation as an insurance company with all its expense, after careful planning and legal advice, an organization has been formed entitled Superior California Hospital Association.

This Association is mutual and non-profit in character. Every effort will be made to keep all expenses at the absolute minimum that members may profit by all monies paid to the Association.

Features that will appeal to every person include choice of any legally qualified physician and surgeon or dentist, and the privilege of going to either the Mater Misericordiae or Sutter Hospital, these two being the only private hospitals of Sacramento accredited by the American College of Surgeons.

Exclusion of certain ailments and expense are only for the best interests of the membership as a whole to avoid undue losses until the Association is well established.

After sufficient time has elapsed, excess reserves built up can be used in widening the latitude of illness or in lowering dues.

The only expense of operation will be for one person to care for the business on a regular salary basis as soon as sufficient membership is obtained, and not more than one clerk to keep the records.

Control has been vested in representatives of the medical and dental societies, the nurses' association, and the two accredited hospitals of the city because of the permanence and reputation of these organizations. In this manner absolute safety is as-

sured. Officers and employees of the Association handling funds will be bonded as well.

Interest of the Sisters' and Sutter Hospitals lies in their efforts in bringing this plan to Sacramento. They

will receive nothing but the usual fees for their services to members, and contracts will be drawn between the Association and the two hospitals covering charges and all other matters.

Books and accounts of the Association will be open to the inspection of members, and periodical reports will be rendered.

Physical examinations are not required. An application made out by the individual will be the only requisite; and his cooperation, together with that of the physician he may select, will be asked in keeping down all undue losses for the Association.

Everyone connected with the Association will profit. The member who becomes ill or has an accident will be free of worry about finances because he will have paid already for his expenses.

The hospitals will receive their usual remuneration through the Association and lower the losses from bad accounts.

The member who previously had to use his spare funds for paying the hospital bills can under this plan remunerate his physician and tradesmen. In other words, the flow of funds through the individual will not be dammed at the hospital, but will maintain its even course through channels of trade and the payment of regular accounts. In this manner illness will be robbed of its devitalizing power on the economic strength of the individual and the community.

A community project of this kind, non-profit and mutual, under the safeguards erected, and with all funds banked and expended in our own city, should appeal to all as worthy of support.

Following are the Articles of Association and By-Laws in full.

We, the undersigned, all of whom are residents of the State of California, do hereby this day associate ourselves together for the purpose of forming an association.

And we do hereby agree:

I

That the name of this association shall be

SUPERIOR CALIFORNIA HOSPITAL ASSOCIATION.

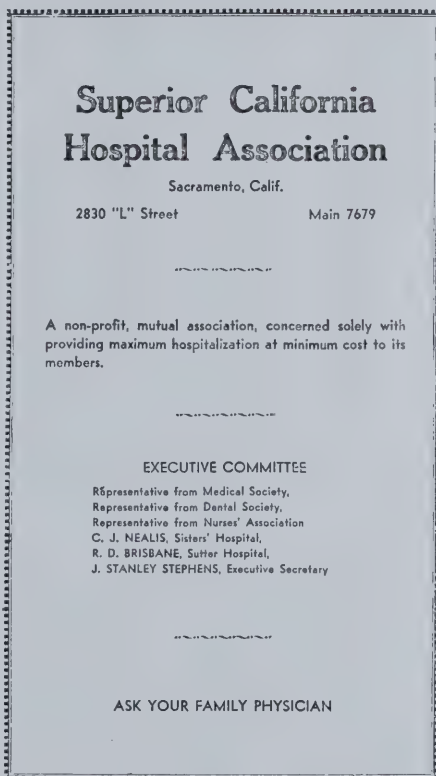
II

That the purposes for which this Association is organized are:

a. To provide hospitalization for its members in event of ailment, illness or accidental injury.

b. To make, and enter into mutual agreements with hospitals for the providing of hospitalization to members of this Association.

c. To do all and everything necessary, suitable or proper for the accomplishment of any one of the purposes or the attainment of any one or more of the objects herein enumerated, or which at any time appear to be convenient, conducive to, or expe-



Here is front page of application leaflet. The inside pages describe features of the plan and the back page contains an application blank. See page 30 for information contained in inside pages of this leaflet, and page 38 for copy of application on back page of this leaflet.

Features of the Sacramento Plan

"A CERTIFICATE of membership will provide the following service:

"Hospitalization, including ward bed and board, use of operating room, administration of anesthetics, laboratory examinations, X-ray photographs, medicines, dressings and general nursing care, while you are a registered bed patient in either the Sisters' or Sutter Hospital of this city, for a period of twenty-one hospital days.

"Should you be away from Sacramento and suffer an injury or sudden attack of illness, you will be provided fourteen days of hospital service in any licensed hospital.

"You will be provided with hospital service for accidental injuries after 12 o'clock noon of the day following date of membership; for sickness or ailments that have their first signs or symptoms twenty days later; for major operations having their first signs or symptoms six months later; and for hernia, removal of tonsils and adenoids, maternity cases, and female ailments, twelve months later.

"Service will not be provided for tuberculosis, cancer, venereal infections, mental or nervous disorders, nor attempted suicide.

"Special medication such as serums, antitoxins, wines and spirituous liquors are not provided.

"As this is strictly a non-profit association, the exclusion of certain ailments and waiting periods before service is effective, is for the sole benefit of the membership as a whole.

"Ward room service as provided by this association applies to two-bed ward only. Private room may be had at either hospital by paying the difference between the ward and room rates directly to the hospital.

"There is no medical examination required, merely complete the application. If you are in normal physical condition, a Certificate of Membership will be issued to you, setting forth in detail the extent and limit of service provided by this association.

"Men, women and children are eligible for membership between the ages of one and fifty-five.

"All dues paid by members are deposited in the treasury of the association. When a member requires hospitalization, his bill is paid directly to the hospital from these funds. No money is paid the hospitals except for service furnished members of this association.

"The membership fee for an individual or family is \$1. This is payable at time of becoming a member. (In groups this membership fee is waived.) Dues for each person are \$1 monthly, payable in quarterly installments. (In groups this may be paid monthly.)

"Note: In sending in application for membership attach membership fee of \$1 plus quarterly dues of \$3 for each individual applicant.

"Supervision and management of this association is vested in an Executive Committee composed of representatives of the Medical Society, Dental Society, Nurses Association, the Sisters' Hospital and the Sutter Hospital. Because of the permanence and reputation of these organizations, absolute safety is assured the members.

"Last year in Sacramento County, 16,309 men, women and children entered the three hospitals for treatment. This represented approximately one person in each nine of the residents of this county.

"The average hospital bill is between \$100 and \$125.

"As this is strictly a community association, may we ask that you solicit your friends to become members. The larger the membership, the greater the service and the lower the dues."

dient, for the protection or benefit of this Association or its members.

III

That Sacramento, California, is the place where the principal business of this Association is to be conducted.

IV

That this Association is not organized for profit but for the mutual benefit of its members.

By-Laws

ARTICLE I

Section 1. Membership in this Association shall be limited to those persons residing in that portion of the State of California generally known as Northern California

Section 2. All applicants must be in normal physical condition and between the ages of one and fifty-five years.

a. The Executive Committee may waive such age limits when in their opinion it would be for the best interests of this Association and its members.

Section 3. All applicants must complete an application on regular forms provided by the Association; and the Executive Secretary on behalf of the Executive Committee shall have the power to accept all applications, subject, however, to the right of the majority of the Executive Committee to accept or reject.

Section 4. Each individual or his guardian, or each family, shall upon approval of application or applications, be given a Certificate of Membership containing such information as the Executive Committee may deem necessary, upon condition that he or they abide by all By-Laws or rules of this Association.

Section 5. All Certificates of Membership shall be signed by the Secretary of the Association and the Executive Secretary.

Section 6. The Executive Committee shall have the power and it shall be their duty to terminate the Certificate of Membership of any member, and to terminate all rights of any member in the Association, whenever he is or becomes undesirable from any cause whatsoever, or

whenever he is or becomes undesirable for membership on account of conduct which would tend to injure this Association or bring it into disrepute.

ARTICLE II

Section 1. In accordance with its By-Laws, this Association shall provide its members in time of illness, ailment or injury, with hospitalization which shall include ward bed and board "general" nursing care, use of operating room, administration of anesthetics, laboratory examinations, X-ray photographs, medicines, and dressings, while the member is a registered bed or "in"-patient at either the Mater Misericordiae or Sutter Hospital, located in Sacramento, California.

Section 2. Such hospitalization shall be provided:—for accidental injuries sustained by the member after twelve o'clock noon of the day following the date of member's Certificate of Membership; for sickness or ailments that are contracted or have their first signs or symptoms more than twenty days later; and for illness or ailments requiring a major operation that

are contracted or have their first signs or symptoms more than six months later.

a. The aforesaid intervals following date of member's Certificate of Membership, shall be known as the effective dates of the Certificate of Membership, and shall remain so as long as there is no default in payment of dues.

Section 3. Hospitalization of any member must be only by recommendation of a legally qualified doctor of medicine or dentist who is recognized by the Mater Misericordiae Hospital or the Sutter Hospital of Sacramento, California, or who is on their respective medical staffs, as long as said hospitals are fully accredited by the American College of Surgeons.

Section 4. A report must be made by the member or his representative when claiming hospitalization under any Certificate of Membership, to the Executive Secretary of this Association within ten days from date of admission to any hospital, on forms provided by this Association, and must include a statement by the attending physician or dentist.

Section 5. This Association will provide hospitalization for hernia, tonsillectomy, adenoidectomy, maternity, or for diseases or injury accidental or otherwise, to, of, or in an organ of the body not common to both sexes, after twelve months from the effective dates of a member's Certificate of Membership.

Section 6. This Association shall not be required to provide hospitalization for tuberculosis, cancer, venereal infections, mental or nervous disorders, or attempted suicide.

Section 7. Should it be necessary, or should any member of this Association so desire, he may have a private room at said hospitals by paying the difference in rates between such private room and the regular ward rate, directly to the hospital in which he is a patient or a guest. Likewise, "special" nurses if required or desired will be provided by the member himself and not by this Association.

Section 8. The total limit for hospitalization for any member shall not exceed twenty-one hospital days in any one calendar year except as provided in Section 9 of this Article.

Section 9. In case of bona fide accidents or injuries to members in good standing in the Association while absent from their usual residence, hospitalization may be provided in hospitals other than those specified for a period not to exceed fourteen hospital days.

Section 10. Hospitalization as provided by this Association shall not include serums or antitoxins, wines or spirituous liquors, more than one cystoscopy in any calendar year, or X-ray, clinical laboratory or other examinations, or treatments, ordinarily performed in the offices of legally qualified doctors of medicine or dentists.

Section 11. Where the member is entitled to receive hospital service or compensation for injuries from a source provided for by law, this Association shall not be liable for, nor render service or treatment of any kind for such an injury or ailment.

Section 12. In the event of emergencies this Association will furnish hospitalization as hereinabove specified as rapidly as may be possible.

ARTICLE III

Section 1. Each individual applicant shall pay a membership fee of \$1.00 when making application for membership for

himself or family. In event of rejection of application, such membership fee shall be returned to the applicant.

Section 2. Each member of this Association shall pay quarterly dues to the sum of three dollars, which sums shall be due and payable on the first day of February, first day of May, first of August, and the first of November, of each year.

Section 3. Five or more members of one profession or business organization may be accepted together with members of their immediate families as a "group."

a. In the case of "group" service, the Executive Committee shall have the power to change the date of payments of such dues and also to place such dues on a monthly basis. In no event, however, shall these be less than one dollar monthly.

b. In the case of any group whose ratio for hospitalization is found to be higher than the average, higher dues may be assessed by the Executive Committee with the consent of the group or groups.

Section 4. If any member shall fail to remit or to pay such dues in time to have the same in the office of this Association within fifteen days from the date on which said dues are due and payable, his Certificate of Membership shall then and there be terminated without notice, and all of his rights under such Certificate of Membership shall immediately cease.

Section 5. This Association may reinstate the Certificate of Membership of a lapsed member by the acceptance of all over-due dues; whereupon the effective dates of Certificate of Membership shall be changed as follows:—for accidental injuries sustained by the member after twelve o'clock noon of the day following such acceptance; for illness or ailments, ten days later; and for major operations, thirty days later.

ARTICLE IV

Section 1. The affairs of this Association shall be managed by an Executive Committee composed of not less than five or more than seven members, that shall include the following:—One representative from each of the following organizations:—Mater Misericordiae Hospital, Sutter Hospital of Sacramento, Sacramento County Society for Medical Improvement, Sacramento County Dental Society, Sacramento County Nurses' Association. The Executive Secretary of this Association shall also be a member; and one member shall be appointed by the Executive Committee from the Association membership.

Section 2. The Executive Committee shall act in the capacity of legal representative of and for this Association in all matters pertaining to business of this Association, and shall exercise general supervision of all books of accounting, moneys and property held or owned in the name of the Association, and shall render a written report annually on all matters pertaining to the Association for the information of members and as a matter of record.

Section 3. The Executive Committee shall hold meetings monthly at the time and place decided by them.

Section 4. The Executive Committee shall have the books of the Association audited at least yearly by a certified public accountant.

Section 5. The Executive Committee shall see that all employees of this Association handling or in charge of any money or property of this Association are properly bonded.

Section 6. The Executive Committee shall elect a chairman from its members whose duties shall be to preside at all meetings of the Executive Committee.

Section 7. The Executive Committee shall elect a Secretary-Treasurer from its members who shall keep the minutes of all meetings of the Executive Committee; and on behalf of the Executive Committee shall receive and disburse all funds of this Association, and shall countersign all checks issued by this Association.

Section 8. The Executive Committee shall elect an Assistant Secretary-Treasurer from its members whose duties shall be to act in place of the Secretary-Treasurer in case of absence or illness.

Section 9. The Executive Committee shall appoint and place under contract an Executive Secretary and any other employees found necessary to carry on the business of this Association.

a. It shall be the duty of the Executive Secretary to supervise and manage the affairs of the Association under control of the Executive Committee.

ARTICLE V

Section 1. Meetings of the membership of this Association shall be held annually during the month of June at a suitable place and time as may be arranged and designated by the Executive Committee.

Section 2. Sixty per cent of all monthly receipts from membership or other dues shall be set aside in reserve monthly against demands for hospitalization of members of this Association. Depositories for funds of this Association shall be selected in rotation by the Executive Committee from banks of unquestionable standing.

a. This section shall be construed to the effect that all overhead expenses be kept at the absolute minimum, and that as income grows an increasing percentage of same shall be set aside as reserves, and as the Executive Committee shall decide from time to time.

Section 3. Any expenditures other than hospital expense, salaries, and normal operating expenses of this Association, in excess of \$50.00 must have the approval of the Executive Committee. The Executive Committee shall also audit monthly at their regular meetings all expense accounts and claims paid.

Section 4. Should there be any difference of opinion regarding hospitalization arising between any member and the Association, such difference shall be left to a Board of Arbitration composed of one representative chosen by the member, one representative chosen by the Executive Committee, and one representative chosen by these two. Findings of this Board shall be final.

Section 5. These By-Laws may be amended, added to, repealed or substituted, at any regular meeting of the Executive Committee by a majority vote of the Committee present.

WE, THE UNDERSIGNED, constituting the entire membership of the Superior California Hospital Association, do hereby approve and adopt the By-Laws heretofore designed and enumerated.

Watch for another article on group hospital insurance in the next issue.

How Orange Memorial Hospital Solves Housekeeping Problems

Cleaning of 80,000 Square Feet of Room Floors and Mile of Corridor Just a Part of Department's Responsibilities

By MARTHA BLANCK

Housekeeper, Orange Memorial Hospital, Orange, N. J.

THE work of housekeeping in the average home and the problems of housekeeping in a large institution, particularly a hospital, have very little in common. The housewife has only her own household to satisfy, whereas in a large institution which is operating day and night, there are many persons to be served and a great many different conditions to be met. Workers in widely different places must be supervised, and materials and equipment have to be properly safeguarded. For these reasons organization and constant supervision are necessary if the results are to be satisfactory.

I am assisted in my work by two assistant housekeepers, both of whom have the ability to meet emergencies and to manage and get along with the employees.

There are 48 persons in my department and harmony must exist. I cannot entertain employees' troubles, nor do I allow the carrying of tales from one employee to another. I try to keep them happy and always interested in their duties. An employee happy in his work, you will generally find fulfilling his duty in a systematic way.

A great deal of my work is done at my desk. I have a system of checking up on reports so that I know what is going on on each floor at any time of the day. I know where every maid or man is and how far along she or he is with the work in hand. I keep records for future reference so that the responsibility can be checked where later inspection reveals unsatisfactory work or breakage of any kind. At the same time I have a record of the cost of the various operations per hour, the number of cleaning hours involved and the frequency of cleaning.

The force we have at Orange Memorial is comparatively small for the work to be done, and to keep everything spic and span, the cleaning force must meet and solve many different problems.

Some Figures on Housekeeping in Orange Memorial

The hospital has 313 adult beds; 75 bassinets.

48 persons in housekeeping department; housekeeper has two assistants.

1,592 windows cleaned monthly or semi-monthly.

Cleaning force covers 80,000 square feet of room space and 5,000 linear feet of corridors.

Linen and sewing rooms under supervision of housekeeping department.

54 different items made in sewing room; an average of 927 new pieces leave workroom monthly.

Daily quota of mending about 150 pieces, not counting nurses' uniforms and aprons.

The hospital uses between 4,500 and 5,000 pieces of linen daily.

HOUSEKEEPING PERSONNEL

The housekeeping department employs as its cleaning force:

- 7 cleaners
- 2 housemen
- 2 porters
- 2 nightmen
- 1 paper baler.

One nightman operates the private visitors' elevator till 10 p. m. From that time on he cleans offices on the first floor and has to be on hand for the night clerk in emergencies.

One nightman is stationed as cleaner in the basement for the clinics and as help in the accident room in emergencies. The accident room has an orderly, but most of the time the night cleaner is kept busy there also.

One of the seven cleaners works only one-half day for the hospital, during the morning hours. From 1 p. m. this man is employed at the Metcalf Institute of Radiotherapy. The cleaning there is also supervised from the housekeeping department.

Twenty kitchen and chamber

maids on the different floors complete the force of the department.

Two elevator operators, also employed by the housekeeping department, have to keep the three elevators dusted and polished, except floors, which are done by the night cleaner, so that interference in running the elevators during the day is cut down to a minimum.

With this small force it is only possible to do the work by the greatest economy of time and a system that has to be kept up under all circumstances.

I always try to have on call several relief workers, men as well as maids, perfectly competent in the routine of every kind of work that is assigned to them, so that in case of sickness I can replace a sick employee without disturbing the routine of work and without inconvenience to doctors and nurses.

Constant watchfulness is maintained to discover people able to carry a certain amount of responsibility. If one of the regular employees leaves or is discharged, he or she will be replaced by a relief worker and another person will have to be taught to take the place as a relief worker.

CLEANING ROUTINE

Each employee works on a fixed schedule. This schedule is handed out to each one when starting work at the hospital, and each change in the routine is marked on his schedule, so that the man has no excuse for not knowing exactly what to do, and any slackness of the employee can be traced.

Every morning between 7 and 8:30 the cleaners have certain rooms and offices to clean. At 8:30 they have to report at the housekeeper's office and the work for the morning is assigned to each one. At 1 o'clock they report again and the work for the afternoon is given out. This work is laid out in advance on a basis of requests that come from the different departments for room clean-

ing, wall washing, moving furniture, or whatever is asked for.

As each patient is discharged, the room occupied must be given a thorough general cleaning. This includes removing stains and finger-marks from walls and doors, washing furniture, windows and radiators, washing and polishing floors and dusting shades and lighting fixtures.

Besides this extra work there is always monthly routine work to be done. All corridors, kitchens, stairs, storerooms, ice plant, shops, dining rooms and the pharmacy get an extra monthly cleaning besides the daily cleaning. This extra cleaning includes window washing, floor and surface scrubbing, mopping or polishing floors. The walls are looked over for stains and finger-marks.

All windows, 1,592 throughout the buildings, are cleaned once a month, some of them every 14 days.

All patients' rooms, corridors, kitchens, storerooms, offices, etc., are thoroughly cleaned, including wall washing, etc., twice a year. Of course, wall washing in rooms that have infectious cases is done as soon as a patient leaves.

The cleaning force at Orange Memorial has to cover approximately 80,000 square feet of room space and 5,000 lineal feet, almost one mile, of corridors, exclusive of Austen Hall and the service building.

In the first six months of 1932 we cleaned 616 patients' rooms. This is in addition to the daily cleaning that is done by chambermaids on the floors. In cases of rooms occupied for a few days only, these rooms, when not otherwise necessary, are cleaned by the maid on the floor.

It is necessary to keep the cleaners working at a high peak of efficiency and under constant inspection, but inspection carried out in such a way as not to destroy the interest of the employes in their work.

Every effort is made to keep the basement and upper floors insect and rodent free, and I can say that fortunately this is only a minor problem with us. Every cleaner and maid has strict orders to report at once if any of these pests are seen. A regular exterminating service from outside and from my own force is at hand to clean up any trouble of this sort wherever it crops out.

The housekeeping department has its own storeroom. All cleaning supplies and materials are dispensed by one of the assistant housekeepers, being obtained from the general storeroom and given to the employes as needed. When a new broom, mop, pail, electric light bulb, etc., is given out, the old one must be presented



"The cleaning force at Orange Memorial has to cover approximately 80,000 square feet of room space and 5,000 lineal feet, almost one mile of corridors."

before a new one may be issued. Thus a constant check is kept and the expense of needless replacements reduced to a minimum. We keep a record of supplies used and to whom handed out, so that it is possible to check up on a careless employee.

Most of the employes working for the housekeeping department work from 7 a. m. till 5 p. m. except kitchen maids. These work from 7 a. m. till 7 p. m., with three-quarters to one hour off between meals.

Every employe has a time card to punch, coming and going. Each time someone is late a 25-cent fine is deducted from his or her salary. In repeated cases the employe is severely warned. If that does not help, the fine will be 50 cents in each case or discharge. This system gives good results. There are not many late.

Pointers on Personnel

Employes punch time card; are fined 25 cents for tardiness; for repeated tardiness, 50 cents or discharge.

Several relief workers constantly available to substitute for absentees or to replace those who resign.

Working time of department employes, 7 a. m. to 5 p. m., except kitchen maids who work from 7 a. m. to 7 p. m., with time off between meals.

Employes report to housekeeper morning and afternoon for assignments out of ordinary routine which is clearly explained when employe is hired.

THE SEWING ROOM

The cleaning is not the only problem. Linen and sewing rooms are very important factors in the work of the department.

The linen room has one supervisor and four helpers; the sewing room four seamstresses. In the sewing room are two electric Singer power machines for heavy work on canvas and padding and three electric sewing machines for general work. Not only the mending is done here, but all canvas bags for the laundry, detachable bodies for linen baskets, maids' uniforms and aprons are products of the sewing room. Under these circumstances it is possible to save 25 to 60 per cent on each article.

There are about 54 different items of surgical supplies which are made in the sewing room, such as masks, doctors' and nurses' operating caps, certain kinds of sheets, binders, etc.

An average of 927 new pieces leave the workroom each month, including draperies, curtains, chair covers, couch covers, pillows, etc. All departments of the hospital have to ask for new articles or replacement of old ones on requisition forms. A record is kept showing what is used in every department and the cost of material and labor.

We generally have about 150 pieces of linen to mend each day, not counting nurses' uniforms and aprons. One of the seamstresses is constantly busy with mending alone. When necessary, one of the others has to help.

(Continued on page 44)



Ontario Convention Is a Huge Success

WITH practically every hospital in Ontario represented and a registration of over 400, the 1932 Ontario Hospital Association convention in Toronto was replete with excellent addresses, papers, round table conferences, and general discussions of the most practical nature. These centered chiefly around hospital economics, nursing, medical staff relations, and convalescent care.

The convention was most ably presided over by F. D. Reville, chairman, board of trustees, Brantford General Hospital, Brantford, and president of the association. Much credit for the success of the meeting and the exhibit was due to Dr. Fred W. Routley, honorary secretary, and Miss Dorothy Dart, assistant secretary.

An outstanding feature was the address of the Honorable Dr. J. M. Robb, minister of health for Ontario, under whose department come the hospitals. Doctor Robb manifested a sympathetic understanding of hospital problems. In discussing the nursing problems the Minister explained that the department of health had no desire to dictate to hospitals but merely to lay down reasonable standards that every school of nursing should meet. He regretted the fact that the hospitals of Ontario were turning out many more nurses than could find employment.

Another highlight was the session on nursing which was devoted to a very illuminating discussion of the report of the Joint Study Committee on the Survey of Nursing Education in Canada. This report, one of the most complete on nursing education ever published, was made possible through the cooperative efforts of the Canadian Nurses' Association and the Canadian Medical Association. In order that the report might be of the greatest value, a national committee was appointed to study it and similar committees are being appointed in each province. These study committees consist of physicians, nurses, hospital trustees and executives.

Discussion on the report was opened by Dr. Stewart Cameron, Petersborough, chairman of the National Joint Conference Committee. He pointed to the fact that the subject of this voluminous report would be the basis upon which a program of improvement of nursing education could be based for the next eight to ten years.

Miss Jean Brown, Toronto, director of the Canadian Junior Red Cross, discussed the report from the standpoint of "The Distribution of Nursing Service," while Miss Muriel McKee, superintendent, Brantford General Hospital, spoke "From the Viewpoint of the Hospital Administrator." The symposium was brought to a close by Dr. George Young, Toronto, who spoke on the report, "As the Physician Sees the Situation."

An entire session was devoted to convalescent care. A most comprehensive report was presented by Dr. Harvey Agnew, Toronto, secretary, hospital department, Canadian Medical Association, on "Important Factors in Convalescent Care." Other speakers on this program discussed various phases of the subject, among whom were Dr. Olive Cameron, Toronto, member of the Study Committee on Convalescent Care, and Miss Laura Gamble, R. N., Toronto, chairman, Study Committee on Convalescent Care. Miss Sara P. Tansy, Montreal, superintendent, Montreal Convalescent Home, gave a most encouraging report on "Ten Years in the Convalescent Field." Another paper of particular interest was that of "Convalescence from a Community Standpoint" presented by Miss May Stewart, Montreal, president, Montreal Convalescent Home Association. The symposium was brought to a close with a paper by Dr. J. E. MacDonald, Toronto, surgeon, Hospital for Sick Children, on "Convalescent Care for Children."

The convention was fortunate in having Dr. F. C. Neal, Peterborough, chairman, Committee on Inter-relations, Ontario Medical Association,

give a brief review of the report on "Hospital Practice and the Medical Profession." This very complete thesis now in print is one of the most useful pamphlets for hospital superintendents and members of medical staffs. It covers all the inter-relationships of the medical staff and hospital management in such a clear and definite manner that many misunderstandings can be avoided if the text is followed.

An address of outstanding interest and impressiveness was that of Hugh Nickle, trustee, General Hospital, Kingston, on "The Hospital, the Trustee, and the State." He rightly emphasized the need that more careful thought be given to the distribution of hospitals. In the discussion Dr. M. T. MacEachern directed attention to the hospital system in Victoria, Australia, where the building of a new hospital must first receive the approval of a non-political state board and the director of hospitals.

In the absence of the Rev. Alphonse M. Schwitalla, St. Louis, president, the Rev. Maurice Griffin, vice-president of the Catholic Hospital Association, addressed the convention in his usual delightful and forceful manner, speaking on the timely subject of "Voluntary Hospitals."

At the banquet the association was honored by two distinguished guest speakers, the Honorable G. S. Henry, Prime Minister of Ontario, and Dr. George S. Stephens, Winnipeg, president of the American Hospital Association.

The round table conferences were conducted by Dr. MacEachern.

R. Fraser Armstrong, Kingston, superintendent, Kingston General Hospital, was elected president of the association, and General C. M. Nelles, Niagara-on-the-Lake, president-elect.—(Contributed.)

WHY JOURNAL IS LATE

A daughter was born to Mrs. Matthew O. Foley, wife of the editorial director of HOSPITAL MANAGEMENT, December 4 at the Hinsdale Sanitarium and Hospital, Hinsdale, Ill.

WHO'S WHO IN HOSPITALS

AN up-and-coming hospital administrator from the great Magnolia State (Mississippi to most of us) is W. Hamilton Crawford who is so actively interested in his job that he willingly travels long distances to discuss current problems with various authorities and who for a number of years has been a regular attendant at a number of state and sectional conventions as well as at national meetings. Mr. Crawford for seven years has been superintendent of the South Mississippi Infirmary, Hattiesburg, and in his efforts to learn more of his lifework and to do what he can to help fellow executives he has shown such a willingness to help that it is no wonder that he has amassed an imposing list of titles in a few brief years. At present he is secretary of the Mississippi State Board of Hospital Inspectors, a body, friends say, in whose formation he was especially active, and he also is 1932-33 chairman of the small hospital section of the American Hospital Association. He has been president of the Magnolia State Hospital Association, and in national associations he has served on various committees, such as the membership committee of the A. H. A. and several committees in the Protestant Association.

J. Z. Kerr, who has been assistant to Dr. Walter E. List, superintendent, Jewish Hospital, Cincinnati, O., in charge of auditing and purchasing, has been appointed superintendent of the Menorah Hospital, Kansas City, Mo., succeeding Miss Beryl B. Anscombe. Mr. Kerr will assume his new duties on December 16. Mr. Kerr has been active in attending state and other meetings for a number of years, and formerly was superintendent of the Ohio Valley Hospital, Steubenville, O. Later he was in charge of the Fort Hamilton Hospital, Hamilton, O.

Dr. H. H. Wilson of Frederick is superintendent of the Western Oklahoma Hospital, Clinton, succeeding Dr. C. Doler, resigned.

Dr. Roy O. Hawthorne, superintendent, Kankakee, Ill., State Hospital, has resigned, and his assistant, Dr. George Morrow, has been appointed acting superintendent.

Dr. J. F. Chalmers, for a number of years in charge of the Santa Fe Hospital, Fort Madison, Ia., has been given a year's leave of absence. Dur-



W. HAMILTON CRAWFORD

Superintendent, South Mississippi Infirmary, Hattiesburg.

ing Dr. Chalmers' absence Dr. L. J. Willis will be in charge and Dr. Der-rill will be assistant.

Nell Abshire and Mrs. Tommie Steele have leased the Wheeler Memorial Hospital, Tyler, Tex.

Mrs. Mary Hickam has resigned as superintendent of Norton Hospital, Norton, Va., and Miss Wyman has succeeded her.

The Chardon Hospital, Chardon, O., now is under the management of Helen Sperry.

Gwendolyn Haverberg, a graduate of New Madison Hospital, Madison, S. Dak., has been appointed superintendent of nurses at that hospital.

Margaret Heisler, Massillon, O., has been appointed dietitian of the Findlay Home and Hospital, Findlay, O., succeeding Marian Brooks, who resigned.

Dr. J. Harvey Jennett has been appointed superintendent of the General Hospital, Kansas City, Mo., succeeding the late Dr. Porter E. Williams. Dr. Jennett was assistant superintendent for several years.

G. W. Olson, for a number of years superintendent of the California Hospital, Los Angeles, recently was appointed to the newly created office of assistant superintendent of the Los Angeles General Hospital, of which Norman R. Martin is execu-

tive superintendent. Appointment to this new position was made on the basis of a civil service examination in which Mr. Olson was rated first among various applicants. Mr. Olson has been extremely active in national and sectional association work and is widely known throughout the field.

Lizzie Goeppinger, superintendent of Culver Hospital, Crawfordsville, Ind., for the last six years, has resigned, and Margaret Meek, assistant superintendent, will be in charge until the board appoints a successor.

One of the most important hospital vacancies to be filled recently was that of superintendent of the Chicago Lying-In Hospital where Jessie Christie had been in charge for so many years. On December 1, Miss P. H. Braithwaite became superintendent of this institution. Miss Braithwaite is an outstanding administrator, having previously been in charge of the children's hospital of the Western Reserve University group, Cleveland, and more recently of Children's Hospital, Pittsburgh.

"Semper Fidelis," of the St. Joseph School of Nursing, Chicago, carries news of the recent appointment of May Kennedy as associate director of the New York-Cornell Medical Center School of Nursing and Director of Pedagogy of that school. Miss Kennedy, an alumnae of St. Joseph's, founded and for 12 years directed the Illinois State School of Psychiatric Nursing.

St. Vincent's Orphan Asylum, Chicago, Sister Camilla, superintendent, has recently opened a department of nursing education for student nurses in schools affiliated with the department of nursing education of De Paul University and for graduate nurses registered in that department. Gladys Sellew, R. N., B. S., M. A., widely known in the field of pediatric nursing, is director of the new department at St. Vincent's. Miss Sellew is author of "Pediatric Nursing" and "Ward Administration," and went to St. Vincent's from Cook County School of Nursing, Chicago, where she formerly was in charge of the children's hospital, and more recently assistant dean. Before coming to Chicago Miss Sellew was assistant professor in nursing education, Western Reserve University, and director of nursing service, Babies' and Children's Hospital, Cleveland.

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encourage those who hope that some recognition of ability and experience in the management of the hospital may be developed, and who also would like to see some practical plan put into effect whereby those now in the field might be enabled to brush up on certain phases of their work.

But, as was pointed out last month, the mere endorsement of an idea or plan means practically nothing in the way of actual accomplishment. As a matter of fact, as word of the recommendation of the committee of a training course for hospital administrators was received, word also came of the "resignation" of a competent and long experienced woman superintendent. Accompanying this news was a statement to the effect that present economic conditions had caused the hospital to make a few changes the board would not otherwise have made. Here is another example of the refusal to recognize that it is not economy to discharge a competent superintendent in favor of a less able or less experienced and lower paid worker.

Another recommendation of the Committee on the Costs of Medical Care which will be received with pleasure by many superintendents is the endorsement of some form of group hospital insurance as an aid in the payment of hospital charges for service to those of moderate means. It is well understood, of course, that this endorsement is of the general idea and not of every plan which may be offered. That the committee looks with favor on the idea of an ethical and practical plan of group insurance will encourage those hospitals which are trying to work out some such plan and which have been heretofore deterred by the lack of authoritative endorsement. Likewise it must be remembered that the committee's endorsement may be used as a sales argument by some commercial organization whose only interest is to sell a plan to a hospital. In different parts of the country hospitals have been urged to sign up for insurance schemes which seem to offer a great deal but which may not meet with the approval of the staff physicians of the hospitals. However, one result of the committee's endorsement of hospital group insurance undoubtedly will be to encourage further study of plans for such insurance. In every instance, of course, the individual hospital should act cautiously and slowly, making sure that the difficulties or objections which have been uncovered by other hospitals are understood. It is well to remember that hospital group insurance still is in the pioneer stage, although successful programs have been inaugurated in different parts of the country.

It was a disappointment to many hospital superintendents to note that the committee did not lend its authority to the recommendation that the government curtail its hospitalization program within certain limits, and for suitable patients to make use of beds in acceptable non-government hospitals. This recommendation was the first one of a minority report.

As readers of newspapers already know, the medical profession has strongly criticized some of the points of the committee's final report, principally its endorsement of group practice. Hospital superintendents in some instances also will oppose the idea of a centralization of hospital facilities in a community, which also is suggested, although a few hospitals already have worked out to some extent the idea of cooperative action of physicians, dentists, pharmacists and others in a medical center. That hospitals should merge into one center is a suggestion that will meet with some opposition, although under given conditions such a merger has been made in a number of communities.

Progressive hospital superintendents also will disagree with the recommendation that there be a lower grade of

The Committee on Medical Costs Makes Its Report

With only a digest of the final report of the Committee on the Costs of Medical Care available at this time, comment is inadvisable on many points. There are several things recommended by the committee which, however, may be mentioned. However, more authoritative and informed comments by Mr. Fesler will be presented in the next issue.

The question of the training of hospital administrators again has been brought up, with the committee's endorsement of such training. Following so closely upon the formal recognition of the value of an experienced superintendent by the American College of Surgeons, as featured exclusively in HOSPITAL MANAGEMENT last month, this suggestion of a committee which has made a study of health service for five years should further

nurses. This idea has been advanced from time to time and sometimes has gained supporters, but those who appreciate that hospital service is improving constantly and must continue to improve will hardly want a reduced standard of nursing education. If anything, the general plane of nursing education should constantly be raised higher, and even then used only as a basis and essential requirement for the nurse specialist, such as the surgical nurse, the obstetrical nurse, the nursing educator, and others who could qualify as nurse specialists only after acceptable further study. If the nurses are to have aids, let these aids be known by some other name than "nurse."

As stated in the beginning, these comments are more or less superficial and are based only on a condensed copy of the committee report. In conclusion it might be said that there are some good features in the report and that the committee's work will serve to arouse thought and action, which will lead to further progress toward the solutions of the important and difficult problems which the committee faced.

How One Hospital Saves \$1,000 a Month

Citizens of one small community undoubtedly felt well pleased when they learned from an announcement in the local press by their hospital board that the institution hereafter was to save about \$1,000 a month. Nothing was said about the kind of service that patients would receive after the radical economies were made effective, in comparison with the service that they had received previously, and the public, it is certain, was under the impression that the saving of \$1,000 a month, a fairly considerable sum in comparison with the operating expenses of the hospital, was to be made simply by putting into effect better management.

But here is how that saving was to be arrived at:

The superintendent was to take over, in addition to her previous duties, the supervision of the dietary department and additional supervisory responsibility in other parts of the hospital. This was made necessary because the dietitian and a supervisor had to go to help bring about the saving.

The supervisor of one department also was to supervise the work of another department, which, while similar in some ways, has special problems and in most hospitals is considered a specialized job.

The biggest saving was to be effected through the discontinuance of the nursing school which would save not only the allowance of about a score of students, and their board, but the salary and board of an instructor, too. To replace these students eight graduate nurses were to be employed at "nominal" salaries, according to the newspaper announcement.

It was freely admitted throughout the announcement that economic conditions were responsible for the economies. Patient bed occupancy had decreased nearly 50 per cent and the smaller number of patients, moreover, were paying lower rates than in previous years.

These details of the savings are reported, not in criticism of this institution, but as somewhat typical of "economies" which a number of hospitals have put into effect at the insistence of trustees, some of whom undoubtedly do not realize that there is little comparison between the care that the patients now are getting and what they received before the savings were made effective. The unfortunate thing is, however, that the public is given the impression that patients receive the same

care as before, and so the public cannot be blamed for believing that if such big savings can be effected so promptly and simply that perhaps there was some truth in the common gossip so often heard concerning the unreasonableness of hospital charges.

Another comment that this situation suggests is this: The discontinuance of the school of nursing was offered as the principal reason for the cause of the saving. But it can easily be seen that the discharge of the dietitian and several supervisors could not be entirely charged up to the change to graduate nursing service. It is likely also that the instructor had other duties in the way of hospital administration, and her discharge has affected a part of the supervision on the floors. In this connection also the use of graduates at the "nominal" salary indicated certainly does not tend to maintain former prevailing salaries for private duty nurses or institutional nurses. So, while those who want to see more schools closed may hail the closing of this school as a victory for "their side" and as further proof of the economic value of graduate service compared with student nursing service, yet actually there were other things involved, things which affected service to the patient as well as the economic welfare of the hospital.

How May This Problem Be Solved?

A number of people who have various types of advisory services and other helps for hospitals frequently complain that superintendents look on them with suspicion and antagonism. Rather typical of the complaints of these people was this recent statement:

"What shall we do about the superintendent who refuses to listen to our suggestions that our organization may be of help to his or her hospital? We have a practical service that is needed by a given institution, and we naturally approach the executive representative of the board, the superintendent. But it is only in exceptional cases that we get a hearing. Since it is our business to provide our service to hospitals and since we approach only those hospitals which we feel can profitably make use of our experience, how shall we continue to contact an institution whose superintendent fails to listen to our program? If we attempt to see the superintendent again this is practically impossible. Our only other recourse is to attempt to contact the board. In doing this we admittedly go over the superintendent's head, but only, as you note, after making every attempt to cooperate with the superintendent and work through him or her.

"I would like to know what superintendents themselves think about this general idea, which may be expressed in this way: 'When a superintendent refuses to consider or listen to a program that apparently offers value to a hospital, what is the next step of those offering such service? Will they be accused of improper conduct in going to the board, or is a direct attempt to contact the board the proper thing to do?' We will appreciate any comments any superintendence may have to make."

Suppose these questions were put up to you, what would you say?

It must be remembered, as experienced superintendents frequently say, that there are a number of people assuming the duties of a hospital superintendent without qualifications. Such a person may not appreciate a service offered to his or her hospital and reject it, although actually it might offer valuable possibilities. What should the individual or organization offering this service do under those conditions?

THE HOSPITAL ROUND TABLE

Know Your Laws

The Ohio Hospital Association in a recent mimeograph bulletin calls attention to the fact that while it has received many suggestions from members as to proposed laws, as a matter of fact there is sufficient legislation. The bulletin continues: "Unfortunately very few hospital executives seem to be acquainted with the existing laws. Through the courtesy of the State Relief Committee we have secured copies of a bulletin prepared by the Ohio Institute explaining the powers and duties of local governments as to methods of relief. This bulletin quotes sections of the Ohio General Code which require townships, cities and counties 'to provide medical service for poor persons needing such attention.' Hospital executives should acquaint themselves and their trustees with the present legislation and do whatever is necessary to secure medical service for the indigent sick of their communities. Incidentally, a large portion of the gasoline tax is being diverted in Cuyahoga County to relief needs."

Many Bulletins

A decided increase in the number of hospitals publishing bulletins is noticed in recent months. A very practical presentation of the value of a bulletin was made at the November Chicago Hospital Association meeting by Charles A. Wordell, director, St. Luke's Hospital, and president of the association. He asserted that hospitals had to make a much greater effort to win support and cooperation and he showed that he practiced what he preached by announcing the publication of a monthly bulletin beginning January 1, 1933. In recent months, as was suggested on page 64 of the last issue, there has been a big increase in the number of nursing school papers. Many are publishing attractive four-page issues of the greatest interest to alumnae and friends, as well as students. Most of the new papers want to exchange with other schools, and a number have begun this practice after the notice to this effect in our last issue. Papers or bulletins or publications which have sent copies to HOSPITAL MANAGEMENT recently are:

"Hospital Advocate," Wesley Memorial Hospital, Chicago.

"Mount Sinai News," Mount Sinai Hospital, Philadelphia.

"Hospital News," Southeast Missouri Hospital, Cape Girardeau, Mo.

"St. Elizabeth's News," St. Elizabeth's Hospital, Chicago.

"The Agnesian," St. Agnes School of Nursing, Fond du Lac, Wis.

"The News-Ray," St. Patrick's School of Nursing, Missoula, Mont.

"The Rosalie," Oak Park School of Nursing, Oak Park, Ill.

"The Nightingale," St. Margaret's School of Nursing, Montgomery, Ala.

"The Open Wound," Minneapolis General Hospital School of Nursing, Minneapolis.

A Fortress of Health



In peace-time as well as in war-time a hospital is a fortress of health. Our fine, modern hospitals are the richest storehouses in the world of medical knowledge and skill. They are health centers which guard the people of their communities.

While your hospital is nursing the sick and the injured, its laboratories are finding new ways to protect your health. As a result of medical research in hospitals, many diseases are disappearing.

Modern surgery, aided by skillful nursing in hospitals, restores to health tens of thousands each year.

In the past, people generally have thought of hospitals merely as the best places to which they could go in case of accident or when an operation was unavoidable. Today people are rapidly beginning to realize that the hospital is the best place in which to be in event of any serious illness.

No home no matter how comfortable, is so well equipped to furnish the many forms of service—any one of which may be needed instantly and imperatively—as a properly conducted hospital.

People unfamiliar with the wide scope of hospital work think only of the patients in hospital beds. One great hospital in New York City treats in its clinics an average of 1400 visiting patients each day. The hospital of the future will play an even greater part in caring for the health of the people. It will be a medical center which radiates health protection.

National, State and County hospitals are supported by taxation. A few private hospitals and sanatoria are on a self-supporting basis. But the great majority of private hospitals are dependent upon endowments and sustaining contributions for bare necessities—proper equipment and needed surgical, medical and nursing staffs.

Appreciate Your Local Hospital.

METROPOLITAN LIFE INSURANCE COMPANY
FREDERICK H. ECHLER, President
ONE SEAGRAM AVE., NEW YORK, N. Y.

Fine Publicity

The Metropolitan Life Insurance Company recently published an advertisement in 20 of the most widely circulated magazines in the country, and, according to J. E. D. Benedict, advertising manager, the magazines in which the advertisement appeared had more than 20,000,000 subscribers. A reproduction of the advertisement appears on this page. In answer to an inquiry from HOSPITAL MANAGEMENT concerning this advertisement Mr. Benedict said, "We felt that this was an appropriate time to put forth such a message for the benefit of the hospitals of the country which will need more than ever the financial support of all who can afford to give. Numerous comments from persons

connected with hospitals are most gratifying."

Every one interested in the development of greater support from the public and a more general appreciation of the problems of hospital service, ought to write to Mr. Benedict thanking him for this splendid service that he has rendered the field.

The Application

Following is the text of the application for membership in the insurance plan offered by two approved hospitals of Sacramento. Details of this plan are described beginning on page 28 and the cover of the application leaflet is reproduced on page 29. The text of the application:

I hereby make application for membership in the Superior California Hospital Association. I understand and agree that the right to service under any Certificate of Membership which may be issued upon the basis of this application shall be barred in the event that any one of the following statements is false and made with intent to deceive.

My full name is

.....
(given name) (initial) (family name)
My residence is.....
My occupation is.....
I am employed by.....
My business address is.....
Please send renewal notices to.....
My age is.... Height.... Weight....
Single or married?... Male or female?...

1. No application ever made by me for life, health or accident insurance has been declined, nor has any renewal thereof been refused by any company or association, except as herein stated.....

2. I am in sound condition mentally and physically. My hearing or vision is not impaired. I have never had nor am I now suffering from or subject to fits, disorders of the brain, or any bodily or mental infirmity or deformity, except as herein stated.....

3. I have never been treated for any disease of the stomach, intestines, kidneys or bladder, except as herein stated.....

4. I have not been disabled nor have I received medical or surgical attention within the past five years, except as herein stated.....

5. The last physician I consulted was.....

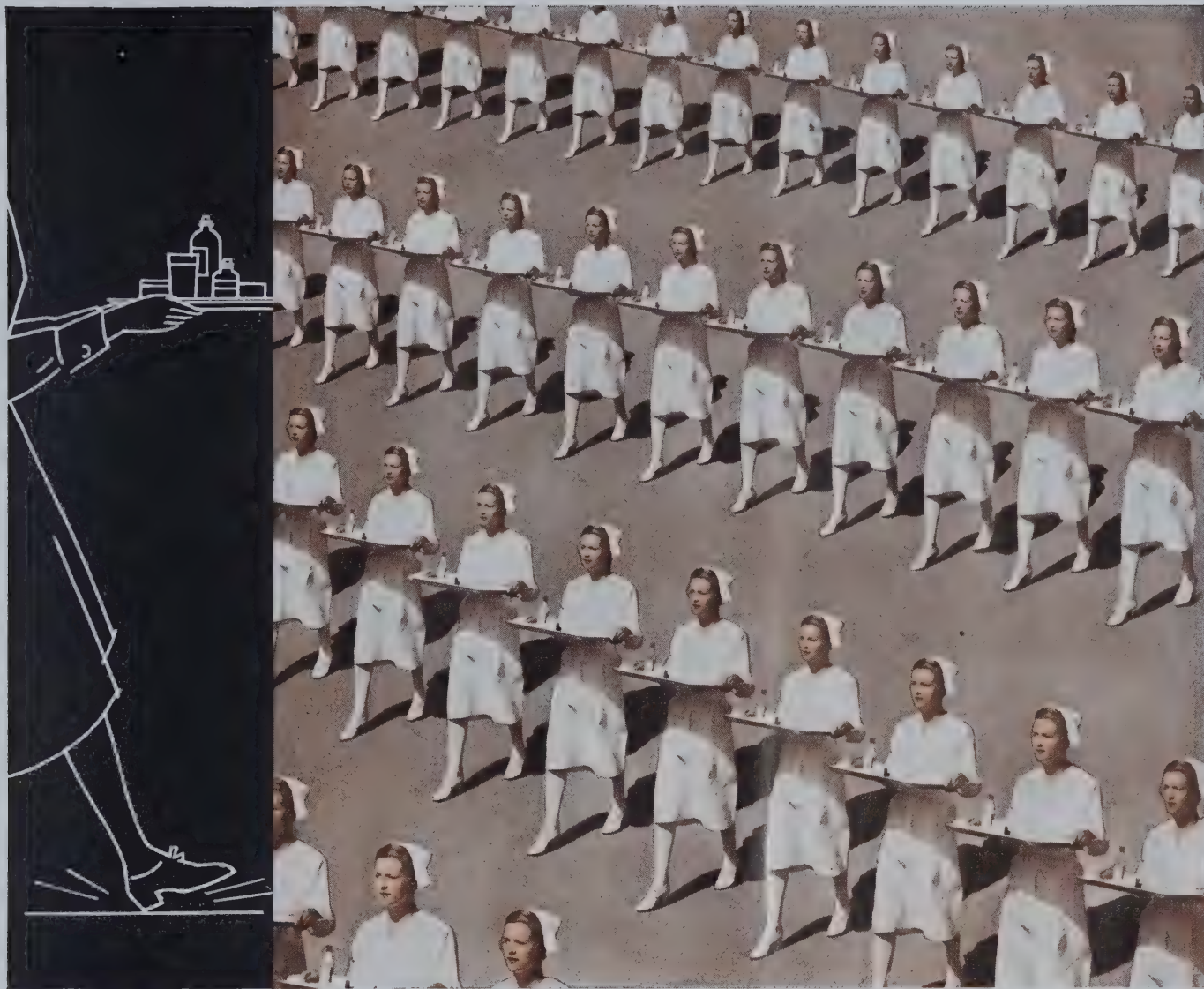
6. I have never undergone any surgical operation, except as follows:.....

If accepted as a member I agree to abide by such by-laws as are now in force or which may be hereinafter amended or enacted. I further understand and agree that no service shall be provided me for any disease, ailment or injury nor complications arising therefrom for any previous disability which I have suffered.

Dated at Sacramento, Cal., this day of 193.....

Signature of applicant (Mr. Mrs. Miss)

Recommended by



Tramp . . tramp . . tramp *the girls are marching . . .*

DAY AFTER DAY—year in and year out—the nurses' army marches from eight to thirteen miles a day! That's no haphazard estimate; it is the actual showing of pedometers worn by hospital nurses while going about their ordinary day's work.

No wonder, then, that the records of forty-five new hospitals show that linoleum is the leading resilient floor today. No wonder that nurses so quickly *feel* the difference after resilient Sealex Linoleum Floors are installed. Sealex Floors have just the right amount of "give" to conserve energy and good nature in the course of a nurse's long day's hike. Patients, too, welcome these noise-reducing, eye-pleasing Sealex Floors.

Don't overlook other important advantages of Sealex

Linoleum Floors. They're sanitary—easy to clean and keep clean. Durable, they withstand many years of heavy traffic. And they're not expensive—even in the more decorative types.

Write our Hospital Floors Department for further details and for complete information on our Bonded Floors and Bonded Walls Service—expert installation which includes Sealex materials backed by Guaranteed Bonds. CONGOLEUM-NAIRN INC., KEARNY, NEW JERSEY



The Laundry Department

Gas Heated Laundry Equipment Turns Red Ink to Black

Emory University Hospital Takes Advantage of Laying of Main Right Near Its Laundry Plant; Remarkable Savings Reported for Machinery

By ROBERT S. HUDGENS

Assistant Superintendent, Emory University Hospital, Atlanta, Ga.

FOR many years we "wished for" a laundry. We were converted to the belief that a plant of our own would ultimately save us money, but always under the barrage of initial costs our courage failed us. Then came natural gas to Atlanta and the offer of gas heated laundry machinery and the wish became reality.

Such a statement is not intended to imply that vendors of steam laundry equipment are extortionists. The fact is that their machinery can be bought at a figure favorably comparable to gas heated units. We were influenced by other factors, which are not likely common to ourselves alone. For example, our steam is purchased from the central heating plant of Emory University. The steam, after travelling nearly half a mile, reaches us at a pressure of only 40 pounds. A steam laundry should have a pressure of 100 pounds. Since

the hospital is only one of some 15 buildings, it was obviously too expensive to step up the central plant to the needs of a laundry in one of the several buildings. A booster at the hospital or a special boiler installation offered a full measure of structural and financial problems, but just outside the laundry location ran a gas main. This could be tapped at an institutional rate which would not be prohibitive. Naturally we adopted gas heated machinery and from our experience so far, would think that many hospitals, with less inducement than we experienced, would find it profitable to do likewise.

The fact that gas has been directly applied to certain units of our plant does not mean that in appearance, organization, or operation our laundry looks strikingly different from the more conventional steam counterpart. The similarities be-

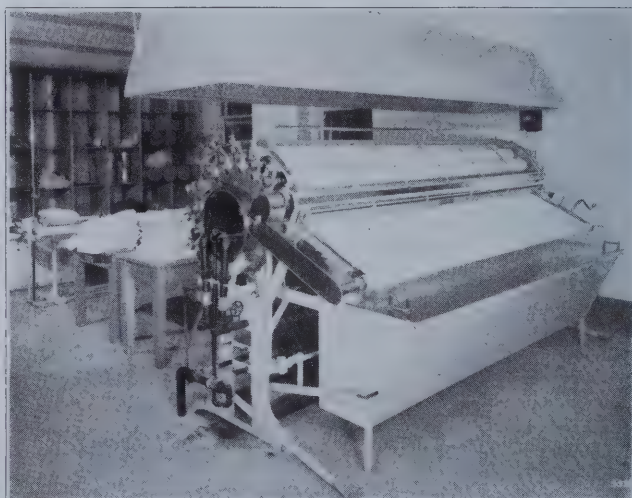
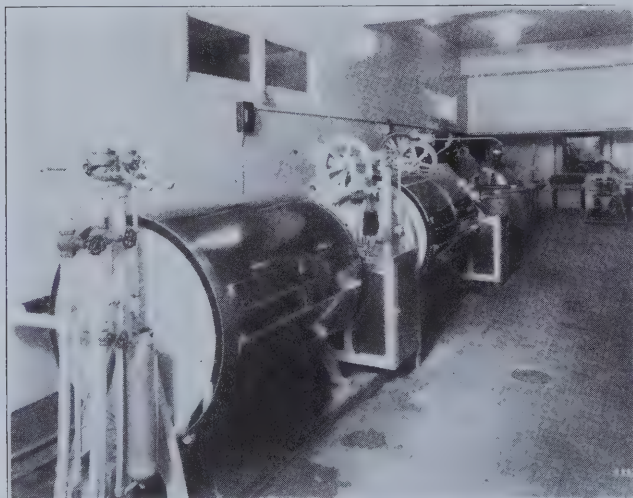
tween the two types so outweigh the dissimilarities as to make differences relatively unnoticeable. This is best illustrated by the following brief description of units installed.

WASHERS: These are regular equipment. They are tied into the steam, hot and cold water lines of the hospital. They are both direct motor driven and equipped with Huebsch Automatic manifold valves.

EXTRACTORS: Two 30-inch, motor driven Fletchers, each with timing device, were selected.

PRESSES: Three Pantex steam presses are operated from a three horse-power gas fired, automatic boiler, 16x29 inches, located in the basement under the laundry.

FLATWORK IRONER: This is the item, the "innovation," which has attracted so many inspections and stimulated so many inquiries. Manufactured by the Chicago Dryer Company, this machine has eleven rolls 104 inches long, a one pass speed variable of eight to forty lineal feet per minute, a capacity of some 2,000 pounds dry weight daily, and numerous automatic safety features. It is a well built, practical machine, handsomely trimmed with monel metal.



Two views of the laundry, Emory University Hospital.

RESIDUE

One method of determining nonvolatile organic and mineral impurities in alcohol is to evaporate a given quantity and weigh the residue. Pure alcohol should not contain more than .003% grams per 100 C.C. of residue. This balance used by Rossville, is accurate to 1/10 of a milligram, or one four-millionth of a pound. It is used to determine residue and assure uniform Rossville purity.



Atlanta
Baltimore
Buffalo
Boston
Chicago
Cincinnati
Cleveland
Detroit
Grand Rapids
Kansas City, Mo.
Louisville
Newark
New York
Philadelphia
Pittsburg
St. Louis
St. Paul
San Francisco

Rossville
THE SPIRIT OF THE NATION

UNIFORM ALCOHOL

NATURALLY, all alcohol is not alike—there are many kinds and grades—alcohol made from molasses is used for some purposes, alcohol made from grain is used for other purposes, and for the most exacting uses is made according to private specifications. Purity and clarity are necessary and should be uniform. A grade known by a definite brand name, or a specification alcohol, should be and can be uniform. Because sufficient care is taken Rossville alcohol is held to certain standards. It is uniform.

Three important factors assure you this uniformity.

1. Rossville alcohol of all grades is constantly tested, checked, and double-checked by a dozen tests to verify, maintain and guarantee consistent quality.
2. Rossville production facilities include ample capital resources, strategic plant and warehousing locations, ultra modern manufacturing equipment.
3. Rossville distilling experience covers a period of 84 years, and at all stages of this history the Rossville product has enjoyed the reputation for maximum quality just as it does today.

ROSSVILLE COMMERCIAL ALCOHOL CORPORATION

Lawrenceburg, Indiana

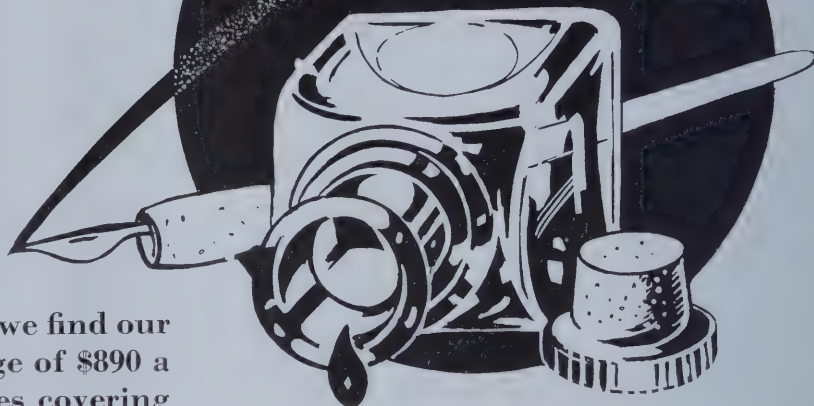
New York, N. Y.

No More

"THE depression has been hard on hospitals. We chose at 'life's darkest moment' to put in our new laundry at a cost of \$12,000.

At the end of the first year we find our laundry saving us an average of \$890 a month! That saving, besides covering all payments on the laundry equipment, is the only thing that keeps us from dipping into the red ink again!"

ROBERT HUDGENS, Asst. Supt.
Wesley Memorial Hospital,
Emory University, Georgia.



● THIS EQUIPMENT

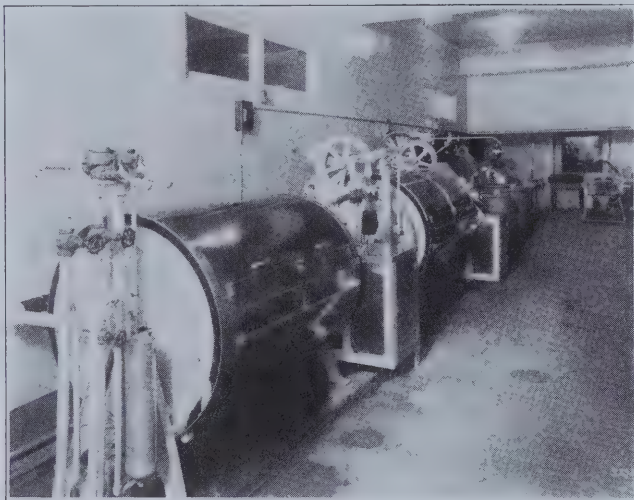
went into the
Emory University Wesley Memorial Hospital

Chicago 11-roll gas-heated Ironer. This innovation forms the nucleus of the institutional gas heated laundry plan. Has a capacity of 2000 lbs. or more daily. Takes flat work direct from extractor, dries and irons in one operation. Speed variable from 8 to 40 feet per minute. Produces an unexcelled finish.

Two Chicago Direct Motor Driven Washers. Monel Metal trimmed and equipped with automatic manifold valves. These washers are engineered for simple, quiet, trouble-free design, economical in first cost and in operation.

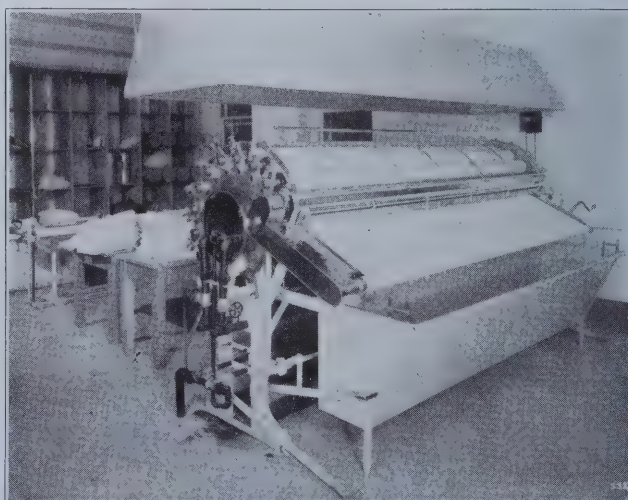
Two Direct Motor Drive Extractors.

Three Laundry Presses operated from gas-fired boiler.



Above—This photograph of the Emory University Hospital installation shows the two Chicago Washers in the foreground.

Right—The Chicago 11-Roll Gas-Heated Ironer, back-bone of this installation.



Red Ink!

HERE'S a fine example of wide-awake hospital management. Expenses were running ahead of receipts. Savings had to be made. The management saw that the laundry check averaged \$1,384.92 a month.

So they put in their own laundry. Since then their laundry cost has averaged \$494.91—a saving of \$890.01 a month!

Of course these people chose CHICAGO Gas Heated Laundry Equipment. This equipment gives the hospital an efficient, up-to-date laundry without the use of high pressure steam—eliminates the installation or extension of high pressure steam facilities. Furthermore, the direct drive principle eliminates overhead shafts and the resulting noise and vibration.

Mr. Hudgens, Assistant Superintendent at the hospital, lists some other important advantages resulting from the operation of their own CHICAGO-equipped laundry. They now have better control of washing, a diminution of losses, and can render better service to guests. He says, "We are operating smoothly and efficiently. The quality of the work is conceded by all who have inspected it to be excellent."

Free Engineering Service.

A survey made before installation by Chicago Dryer Company engineers *positively showed* the savings indicated by the "Cheerful Figures" at the right. Call upon our trained engineers to make a survey in your own plant. Mail the coupon for detailed information.



Cheerful Figures

These figures, compiled by Wesley Memorial Hospital at Emory University, Ga., *prove* the economy of operating a CHICAGO-equipped laundry.

Monthly bill for outside laundry service (even with 50% off retail rates).....\$1,384.92

Average monthly cost of operating CHICAGO-equipped laundry department.....\$632.08

Less cash from guests..... 137.17

Net operating expense..... 494.91

Monthly saving.....**\$890.01**

CHICAGO DRYER COMPANY

2218-28 N. Crawford Ave., CHICAGO

CHICAGO DRYER COMPANY,
2218-28 N. Crawford Ave., Chicago.

Gentlemen: Without obligation on our part, please send details of your free engineering service.

Name

Hospital

City State

TUMBLER: The cylinder measures 36x 42 inches and revolves over three gas burners, each of which consumes from 30 to 40 cubic feet per hour. Controlled by a timing device, the machine turns out 50 pounds dry weight in 30 minutes.

Since the installation of the above equipment we have had a depression average of 78 patients a day. This has not been enough to test the capacity of our plant, which at installation was figured to show a 25% expansion over current needs. The flatwork ironer could easily double the output required of it, since it is now operating only a part of each day. The foregoing is of value in introducing the subject of results obtained. We have saved money at a gain rather than a loss of convenience, but the story is more convincingly told with figures.

The commercial laundry bill for 1931 was \$16,619.04. The company doing the work was low bidder and offered 50% from retail rates, but the fact remained that each month we issued a laundry check averaging \$1,384.92. Since purchasing our own equipment we have in no month exceeded in operation costs one-half this outlay.

Average costs for months of laundry operation:

All supplies	\$197.04
Salaries	337.29
Gas	39.75
Water (1)	22.00
Electric power (2).....	36.00
	<hr/>
	\$632.08
Less cash income from guests	\$137.17
	<hr/>
Total monthly outlay...	\$494.91
Average monthly bill at former commercial rates	\$1,384.92
Less cost of hospital laundry operation ..	494.91
	<hr/>
Average monthly savings to hospital	\$ 890.01

(1) Estimated at twice the sum arrived at by engineer employed to check consumption.

(2) Again twice the sum determined by engineer whose estimate was figured on horsepower and kilowatt hours.

Of this savings to the hospital \$500 a month is being set aside to retire the investment, which will be accomplished in a total of 23 months. After this amount is deducted, the hospital still finds itself \$390.01 to the good. Though this sum cannot be said to be an absolutely exact figure, we have taken the precaution of seeing that water and electric power estimates are large enough to affect the laundry adversely rather than favorably. These amounts are certainly adequate to cover also the cost of the steam. The commercial rate with which our experience has been compared was for a period averaging ninety patients a day, whereas for

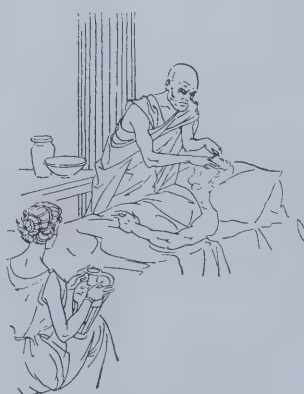
the period of our own operation the daily average has been only seventy-eight. Such variations as these have to be considered, but their maximum effect can have only a minor bearing on the final figure. They tend to be offset by such advantages as result from the control of washing processes, diminution of losses, and service to guests.

Since this article deals with gas heated equipment, it seems in point to stress the fact that total metered gas consumption has averaged per month \$39.75, or for twenty-six working days, \$1.53 a day. It is this which has occasioned surprise.

Finally a word about personnel. In charge of the laundry is a forelady. Under her supervision is an experienced colored wash man, and nine colored women. A check against the rates paid laborers by local commercial laundries shows that we are paying a wage above the average obtaining in the city. We are operating smoothly and efficiently. The quality of the work is conceded by all who have inspected it to be excellent.

The depression has been hard on hospitals. They have been pursuing a phantom known as "black ink." Without our own laundry we should still be in pursuit, but due to economies it has made possible, we have set aside, for the time being anyway, our red ink. The conservatively arrived at savings in this department alone have exceeded by one hundred dollars a month the credit balance reported for the hospital. Deprived then of this economy we should most likely dip again into the scarlet. We chose at "life's darkest moment" to spend \$12,000 only to find that in less than one year's time the investment was not only retiring itself, but was in addition saving more money than the sum by which the institution escaped the red.

Naturally we are enthusiastic!



Housekeeping Problems at Orange Memorial

(Continued from page 33)

Work in the sewing room is done on a schedule of 44 hours per week.

THE LINEN ROOM

In co-operation with the sewing room works our linen room, located in the basement of the building with a narrow gauge track connecting with the laundry.

The hospital has a linen exchange system. The soiled linen sent from the various floors to the linen room is replaced with an equal number of pieces of clean linen.

The soiled linen is collected and put in bags in the different departments. Each department is provided with its own bags, plainly marked to prevent mistakes. Operating, delivery room and isolation linen is not counted when coming from the floor, but is sent in specially marked bags to the laundry, is separately handled there and only counted when returned clean. The linen sent today will be back the next day by noon. All linen returned will be counted and checked again, looked over for mending, and put on shelves for the next day's use. An extra supply is always kept for emergencies. The mending is sent to the sewing room, to be back the next day.

This constant checking up on departments and laundry brings the loss of linen to a minimum. It also shows where linen on the floors is used unnecessarily. In almost every case large differences can be easily explained, based on the number of patients to be cared for or patients requiring special care. The average daily use of linen is between 4,500 and 5,000 pieces, including hospital, kitchen and nurses' linen, doctors' and orderlies' uniforms.

Statistics worked out in the housekeeping department show us exactly the increase or decrease of linen per patient per day.

All linen is marked in the linen storeroom. The linen room, like the sewing room, has its own stock. All material used is listed in inventory ledgers in which are entered all purchases, giving date, quantity and price with the name of the supplier. Every requisition filled from stock is entered and after each entry a balance is struck, so that at all times the exact number of each article on hand is shown.

The re-ordering is done by the housekeeping department in consultation with and through the purchasing department.

THE GREATEST DISINFECTANT NEWS IN 40 YEARS



LYSOL NOW

TWICE AS STRONG
in phenol coefficient

TWICE AS QUICK
in germicidal action

... SAME PRICE
\$1⁵⁰ per GALLON
in lots of 10 gallons or more

Forty years ago, "Lysol" chemists gave to the world an antiseptic whose remarkable germicidal action immediately placed it in the front rank of hospital necessities . . . and quickly made it the largest selling disinfectant in the world.

Today, "Lysol" chemists announce a new "Lysol" . . . a double-strength "Lysol" . . . a "Lysol" that cuts right in two the time it takes to kill infectious germs . . . a "Lysol" that cuts to an absolute minimum the cost of hospital disinfection . . . a "Lysol" that opens up great new possibilities in the field of modern antiseptics.

No longer need hospitals gamble with cheap, unsafe, and weak substitutes . . . No longer need the cost of reliable disinfection be a hospital problem . . . *For the special no-profit-price of "Lysol" to hospitals remains the same . . . \$1.50 per gallon in lots of 10 gallons or more.*

Get your order in early for this new double-strength "Lysol". Hospitals will be served first . . . In fact, no commercial announcement of this radically new "Lysol" will be made until every hospital is supplied. For your convenience in ordering, use the coupon below.



LEHN & FINK, Inc., Hospital Dept. N-12
Bloomfield, N. J.

Will you kindly ship immediately
gallons of the new double-strength
"Lysol" disinfectant.

Your name and title _____

Your hospital _____

City _____ State _____

COMMUNITY RELATIONS

Each Month Sees New Hospitals Using Press Items

EACH month finds superintendents writing to HOSPITAL MANAGEMENT telling of the success they have had in obtaining favorable newspaper attention to problems and needs of the hospital, through the use of the suggested newspaper articles which appear in this magazine monthly.

Here are four more articles.

Just copy them on a typewriter, changing each to suit your own conditions, and inserting the names, figures, etc., as suggested.

Send a copy of the typewritten article to every newspaper, weekly as well as daily in the territory from which you draw patients. Don't forget club and church magazines, etc.

Don't forget to send HOSPITAL MANAGEMENT a copy of one of your articles after it has appeared in print.

Hospital Completes Plans for Christmas

(Week of December 19)

Preparations for Christmas are taking up a great deal of time at Hospital today, according to, superintendent. The Christmas menu has been officially approved and the mere mention of it will make the mouth of anybody "water." Here it is:

(Copy your Christmas menu here)

The hospital also wants to thank the many friends and the clubs and other groups which have offered to assist it in its Christmas program this year. Here are some of the high lights of that program:

(Insert facts about any special features, such as extended visiting hours, singing of carols, etc.)

"Christmas is a very happy day in a hospital, strange as it may seem," concluded "Those who are ill realize that they are far better off in a hospital than in the finest home where aseptic technique and trained personnel, as well as equipment, which they need, are not available. Besides, the spirit of the hospital seems especially recognizable on Christmas."

\$130,000,000 in Free Work Hospitals' Gift

(Week of December 26)

"While people are checking over their Christmas gifts and telling how

generous Santa Claus was to them, said superintendent of Hospital," it might be of interest to say that the most generous group of Santa Clauses in the land are the hospitals. In the year now closing they have given the poor and worthy sick men, women and children of the county something like \$130,000,000 in badly needed service.

"In spite of these huge demands that have been made on hospitals for more than a year, the plight of the hospitals is just being recognized in some quarters. This, of course, may be due to the hospitals themselves, because so many of them have failed to tell the public of their needs.

"This \$130,000,000 Christmas gifts of the hospitals to the public in the form of free care of the poor represents only the work of the hospitals themselves, and does not include the sums represented by the services of physicians, nurses and others. At ordinary rates the services of physicians and nurses would total at least as much as what the hospitals spent."

(If you wish, estimate the expense of free and part free work of your hospital in 1932, and add a sentence covering this.)

Free Service Requests Increase in 1932

(Week for January 2)

"Hospitals, like business houses, make an annual report of their work," said, superintendent, Hospital, yesterday, "but the hospital reports its results in terms of days of service to the sick, and not in units and dollars. It is too early, of course, for us to make a complete report of our work for 1932, but it can be said that never in the history of the hospital has there been such a heavy demand for free and part-free service. Generally speaking, requests for less-than-cost service are about 30 per cent above an ordinary year, and to make matters worse, the income of the hospital, which comes entirely from payments by patients, has materially lessened, due not only to a smaller patronage, but to the much higher percentage of patients

who reserved medium priced accommodations. Like every other hospital, our institution must pay for its groceries, its light, heat and power, and for the labor and skilled service. Reductions in expense have been made, but at all times, the hospital has expressly refused to make any change that would affect the type of service the patients require. That would be anything but economy to the man or woman, who because of 'economical' methods, received an infection that necessitated many additional days in bed.

"Here are some facts about our work in 1932:

"We admitted a total of men, women and children. In caring for these we rendered a total of days of service. We employed a total personnel of In 1932 we served a total of meals."

Hospital vs. Hotel Like Auto vs. Buggy

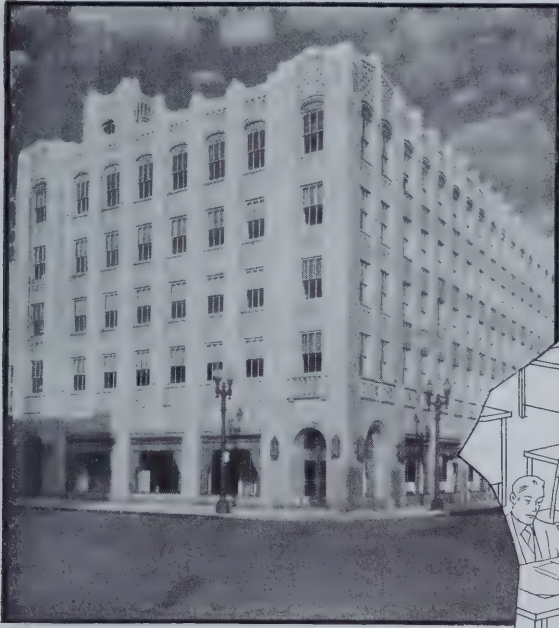
(Week of January 9)

One of the results of the recent agitation in Chicago concerning the fact that the Cook County Hospital is filled to overflowing while private hospitals have nearly half of their beds empty, according to (name) superintendent of Hospital, was to emphasize the expense under which hospitals labor in providing scientific equipment and service, as well as complete "hotel service."

"Few people realize that hospitals begin their service where hotels leave off, as it were," commented the superintendent. "In other words, what good would a lobby, room and furniture, heat, light, power, linens, etc., do a very sick person? What this person needs and must have are supervised and selected menus, nursing and personal attention, and such medical and allied services as laboratory, X-ray, physical therapy, and many others, which the hospital alone offers, all under the general direction of a doctor. No hotel offers service like this, yet many folks think of hospitals only as hotels. It is not stretching the comparison to say that a hotel resembles a hospital only as a buggy resembles an automobile. The buggy has wheels, seat, body, etc., but has no engine. The highly organized medical and allied services of the hospital may be likened to the engine which carries the patient along the road to recovery."

Johnson Automatic Control

*the "Brain" of the
Air Conditioning Plant*



OHIO POWER CO., *Office Bldg.*, CANTON, OHIO

Vernon Redding and Associates
Architects
Mansfield, Ohio

The A. C. Eynon Plumbing Co.
Heating & Ventilating
Canton, Ohio

Cooling and Air Conditioning Corp.
Air Conditioning Engineers
New York City



THE AIR CONDITIONING UNIT IS THE
"HEART" OF THE PLANT . . . THE DUCTS ARE THE
"CIRCULATORY SYSTEM" . . . BUT THE AUTO-
MATIC TEMPERATURE AND HUMIDITY CONTROL IS THE
"BRAIN" WHICH COMMANDS THE WHOLE INSTALLATION

WHEN the control apparatus is JOHNSON, dependability and accuracy are assured. Only the Johnson Service Company offers such a complete line of devices for air conditioning control. Differential Thermostats for sensing outdoor and indoor conditions . . . Dual (or two-temperature) Thermostats . . . Extended tube Wet and Dry-bulb Instruments . . . Velocity and Static-pressure regulators . . . Humidostats.

Consult a Johnson Engineer at the nearest branch office.

MANUFACTURERS
ENGINEERS
CONTRACTORS

*A Single Organization
Operating Through
Direct Factory
Branches*

Automatic Temperature Regulation since 1885

JOHNSON SERVICE COMPANY

Main Office and Factory

MILWAUKEE, WISCONSIN

Branch Offices in All Principal Cities



FOODS AND FOOD SERVICE

How Jewish Hospital, St. Louis, Serves 1,500 Meals Daily

Kosher Kitchen Accounts for Two Additional Cooks; Dietary Department Trains Dietitians; Patients Check Menu Choices

By BETHEL CURRY, B. S.

Chief Dietitian, Jewish Hospital, St. Louis, Mo.

IN looking over the accompanying chart of organization and list of personnel required to serve from 1,200 to 1,500 meals a day, one has every reason to suspect that the kitchen is over-staffed with cooks; however, the Jewish Hospital maintains two Kosher kitchens for Jewish patients of the orthodox faith, which necessitates employing two additional cooks.

In the chart the dotted line represents the contact the chief dietitian has with the various individuals. You will note her contact with the superintendent, with the staff and with the principal of the school; also, that the entire dietary department is under her supervision. From the center of the chart you will notice her direct control of the main kitchen, with one chef responsible to her for the work of the assistant cook, pastry cook, butcher, pot-washer, bus boys, maids, etc.

On the opposite side, you will note the dietitian's direct contact with the buyer who has under her charge at certain periods of their training student dietitians, teaching them the rudiments of purchasing, receiving and dispensing staple supplies for the kitchen.

One assistant dietitian has charge of central service, and to her the dish-washer, bus boys, student nurses and student dietitians are responsible. She also has charge of the employees' cafeteria.

Another assistant dietitian has charge of the nurses' cafeteria, in immediate charge of which is a head waitress, with the help employed in this department, such as dishwasher, bus boys, maids, etc. Student dietitians receive training in this department under her direction. Also, she

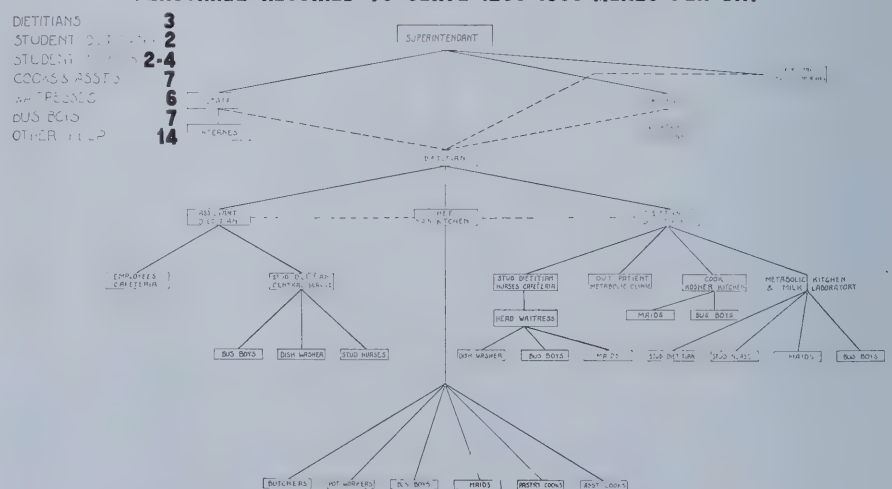
One of the most enjoyable and practical features of the 1932 hospital conference of the American College of Surgeons at St. Louis was a forum at the Jewish Hospital. In the spacious gymnasium of the nurses' home, Miss E. Muriel Anscombe, superintendent, arranged equipment and supplies for actual use, while department heads explained practices. The accompanying paper, one of those given during this forum, indicates the practical character of the program. A set-up food cart and a large plan of the kitchen helped to register details of the department's activity.

is in charge of the out-patient metabolic clinic, the Kosher kitchen, the metabolic kitchen and the milk laboratory, with student dietitians, student nurses, maids and bus boys under her direct supervision.

In this way each assistant receives definite departmental responsibility and is responsible to the chief dietitian for the performance of her duties.

The planning and equipping of the dietary department calls for as detailed and painstaking consideration as the development of any other department in the hospital. The quality of food served to patients is often the principal index in judging the institution. Too frequently hospitals fail to attain a maximum of community good will because of the

PERSONNEL REQUIRED TO SERVE 1200-1500 MEALS PER DAY



An explanation of some of the features of this chart is given in this paper. Note the list of personnel, by positions, in the upper left hand corner.

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PROBABLY NO OTHER FRUIT is more welcome to the average patient than is—pineapple.

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. . . is rich in minerals, providing copper, iron, and manganese—well-known safeguards against nutritional anemia—and calcium and phosphorus in notable quantities . . .

. . . and is a splendid source of vitamins A, B, and C.

These *many* values found to exist in canned pineapple warrant not merely its regular serving, but its appearance on the unrestricted tray *at least once a day*.

Serve it in portions of two slices or as a Pineapple Cup of crushed or tidbits.



{These statements are made only about Canned Pineapple, NOT raw pineapples. The temperatures applied in canning cause a beneficial change of dietetic importance.}

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The fact that there is a direct connection between the appearance of a meal and the amount that is eaten is not news to you. But when you compare your present china, as many hospitals are doing, with this new Adobe ware you may realize for the first time just how important the china itself really is. China is the frame, the "package." Crude in shape, lifeless in pattern, it naturally blunts the appetite, no matter how carefully your food is prepared and arranged. Warm, inviting, it stimulates and, in the case of Adobe, brings out the full brilliance of Nature's own colors in foods.

We urge you to forget for a moment the cares



See what happens when it's rubbed out!

of your office, the pressure of reduced budgets—and to examine this ware at the first opportunity. Compare it with your china by placing a simple diet on its mellowing, soothing surface. Call in physicians, dietitians. Get their opinion. Then and only then can you decide if you can afford to pass by this opportunity to earn the everlasting appreciation of every patient under your care.

Sample stocks of Adobe ware are now in the hands of leading supply dealers in all principal cities. See this assortment of samples. If you have any difficulty in locating a representative number, please write us at Syracuse and we shall see that samples are furnished you. Then if you have any special pattern in mind, you can call on our art staff to supply some suggested specimens in colors. There is no cost for this service. And you may be better satisfied in the end with a pattern exclusively yours.

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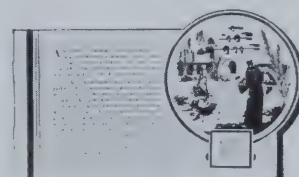


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As the result of recent reorganization, The John Van Range Company is now entirely independent of and unrelated to any other concern in the kitchen engineering and food service industry.

The reorganization

affects only the ownership and executive management. "Key men" in the old organization have become officers in the new; engineers, production operatives, sales and office personnel who have made this the leading service organization in its field are still with us.

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is such that we can handle any project however extensive. Yet small orders command the same courteous attention that has characterized the services of The John Van Range Company for more than three quarters of a century.

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has been increased by removal to our new location in the heart of down-town Cincinnati. Our stocks of miscellaneous small wares, utensils, china, glass and specialties for the day-by-day requirements of our customers have been greatly extended. The mounting volume of our current sales is evidence of the improved service we are rendering.

(We take this occasion to thank our old friends
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hospitals we have not served in the past.)

The John Van Range Co.

EQUIPMENT FOR THE PREPARATION AND SERVING OF FOOD

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partial failure of the dietary department, the faults of which are often basic rather than administrative. Since the maintenance of this department represents 25% of the operating expense, there is an economic as well as service-to-patients problem to be considered.

The expeditious delivery of food to the patient's bedside should be regarded as an important factor in determining the location of the kitchen. The relation of the central kitchen to the receiving department and storage rooms and to the service system and dining rooms are other factors which concern everyone in the hospital, as these aid materially in maintaining the service on a high plane.

The floor plan of the kitchen shown in this article will help one to visualize more clearly the progressive movement of food from point of entrance to line of service. Note the general arrangement with the receiving entrance and storage rooms at the rear. Grouped near the storage rooms are the refrigerators for meat, vegetables and dairy products, with the butcher shop and ice cream rooms opposite the large refrigerators containing these foods. The vegetable preparation room is near the ranges. Note the opening on the side for the convenience of the cook, and the scullery for cleaning the cooking utensils placed in close proximity to the ranges.

The ranges, broilers and ovens are grouped together on one side, with only a heavy partition dividing it from the group of such equipment as rendering pot, vegetable cooker, stock pots and cereal cooker. The table, cupboard and small refrigerators in which is kept food for immediate use are grouped about this section.

In the far corner, provision is made for the pastry cook with her supply cupboard, ice box, sink, table, storage bins for bulky supplies, a storage ice cream unit and bread cutter.

Note the placement of the coffee urns, hot plate, electric toaster and dish cabinet below, with plenty of space between this and the long steam-heated dish warming cabinet on one side and food containers on the other; also, ample refrigeration space for salads and desserts.

Immediately adjoining the large kitchen are the employees' dining room and the special diet kitchen, the latter equipped to cook and serve food for all patients on special diets. The silver burnisher and mixer are near the cooking unit and immediately in front of the ranges is plenty



Here is a drawing of the layout of the kitchens and dietary department of the Jewish Hospital. The author explains some of the features of this plan in the paper.

of space for the loading of carts preparatory to delivery of cooked food to its destination, the dining rooms and wards.

The dotted line and arrows represent the progressive line of service. The soiled dishes are returned from the patients' rooms to the dishwashing room, where the dishes are washed and placed in cupboards opposite the dishwasher.

For centralized service, the trays are set up in the main kitchen and placed in the carts. Liberal space is provided for this as a great deal of floor area is required to set up and load trays expeditiously. (The success of this service depends largely on the speed with which it is carried on.)

We use central service for all private patients. For ward patients, the bulk food is sent up in heated carts and served directly from these carts by the head nurse.

The menus for central service are presented to the superintendent for her approval one week in advance. The individual menus are given the patients the day before to check the food which they desire and are submitted by 5 p. m. to the chief dietitian. From these are made out the orders for the following day. The menus are planned to give a wide enough variety of food that special orders or a la carte service is avoided to a great extent. A special charge is made to the patient for all a la carte orders. The menu card accompanies the tray to the patient to avoid any complaints that might arise as to the patient not receiving what he ordered.

Immediately before the service, the carts proceed as indicated by the arrows. The dishes to be heated, such as hot plates, thermos jugs and soup tureens, are placed in the dish warmer for some time before the

meal is served. The bus boy fills the hot plate with hot water at the sink, as indicated, and the hot foods are placed on the tray; salads and desserts are placed on last. The diet is verified by the dietitian and the menu placed on the patient's tray. The cart, holding 12 trays, is then taken by means of the elevator, which is in close proximity as you will notice on the floor plan, to the floors, accompanied by a dietitian.

With this method of service, there is absolutely no excuse for cold food. A number of hospitals speak disparagingly of central service, but I believe this is due to a lack of proper facilities, rather than the system. Each tray should be equipped with a hot plate with hot water beneath and cover above, thermos jug, thick soup tureen and covered vegetable dishes.

We like the unheated tray cart because it does not require a duplication of service on the division whereas, when the heated cart is used, salads and cold foods must be placed on the trays from other carts on the division, which makes for confusion and possible errors.

Patients on special diets, whether free or pay, are served in the same way as those on general diets. In the diet kitchen, one dietitian, with student dietitians and student nurses in her charge, is responsible for all therapeutic diets. The students not only calculate all special diets under her supervision, but also study why such diets are necessary. They check daily all laboratory findings, such as sugar tolerance, blood sugar, N.P.N., loss or gain in weight, basal metabolism, and the amount of insulin or other drugs given, and record on the patient's chart all food eaten or returned and the substitution required to make up for food returned. Food not eaten by patients on figured diets is weighed and orange juice or milk is substituted for this loss. Any change in diet is explained in detail to the students to keep them in close touch with the results of each and every diet.

The special diet kitchen is in close proximity to the central cooking unit, which makes it possible to prepare such foods as soup and meat in that unit and only vegetables, salads, desserts, etc., in the special diet kitchen. This is done by the maid with the help of the student nurses and student dietitians. All diets are weighed and trays set up by the students and checked by the dietitian. These trays are then taken directly to the patients' rooms by a bus boy accompanied by a dietitian or the nurse.

We feel that serving therapeutic

"During the past nine months our cost of meals has averaged 21.3 cents a meal, subdivided as follows:

\$0.01 $\frac{1}{2}$, groceries
.04 $\frac{1}{2}$, meat
.02 $\frac{1}{4}$, vegetables
.02, fruit
.03 $\frac{1}{4}$, butter, milk and cream
.01, bread
.00 $\frac{1}{2}$, linen, china and supplies
.06 $\frac{1}{4}$, service, salaries,
making a total of 21.3 cents per meal, of which 14 $\frac{1}{2}$ cents represents the outlay for raw food.

"Although every effort is made to maintain the meal cost at a minimum, we are still able to serve even our lowest type employes whole milk, strictly fresh eggs and butter, and once daily some fresh vegetable the year round. We feel doubly responsible for these employes at this time of depression, especially for those who eat only one meal at the hospital."

diets in this way has several advantages. First, there is less chance for mistakes, since the tray is taken directly to the patient after it has been checked. Second, it gives the student nurse a complete picture of special diets from the time they are figured until they are delivered to the patients.

In addition to the routine daily rounds, each patient is seen by someone working in the special diet kitchen every time a tray is served.

As a means of summarizing, each student is held responsible for a case study of some case of special interest. In this the "social history" and its influence on the case, the general health habits of the individual with emphasis on dietary habits, the medical history, physical examination and a discussion of the diet and the patient's reaction to it are recorded.

The services of the dietitian are not limited to the patients in the hospital proper for the dietitian in charge of special diets also teaches in the Health Clinic two days a week. This plan gives an opportunity for close follow-up work of the individual who is admitted to the hospital.



What Chicago Hospitals Pay for Milk

Forty-one Chicago hospitals, members of the Chicago Hospital Association, recently reported to John C. Dinsmore, director, University of Chicago Clinics, that in a recent month they bought 34,845 gallons of bulk milk, for which they paid from 23 cents to 48 cents a gallon. The average price per gallon, based on the 43 quotations reported, was 32.5 cents, with 11 of the 43 hospitals paying more than this, and 19 hospitals paying 30 cents or less.

Mr. Dinsmore, in commenting on the study, at the November meeting of the association, asserted that if all of the hospitals bought all of their pasteurized milk and milk products at the lowest prices paid by any hospital belonging to the association, the 43 hospitals would save \$40,880 on these products alone in one year.

Other prices paid, as reported by the hospitals:

Bottled milk, quart, 8 cents to 12 cents.

Bulk cream, 18 per cent, gallon, 73 cents to \$1.35.

Bulk cream, 22 per cent, gallon, \$1.10 to \$1.50.

Bottled cream, 18 per cent, quart, 26 cents to 45 cents.

Bottled cream, 30 per cent, quart, 35 cents to 60 cents.

Cottage cheese, pound, 7 cents to 15 cents.

Skim milk, gallon, 13 cents to 25 cents.

Bottled buttermilk, quart, 8 cents to 20 cents.

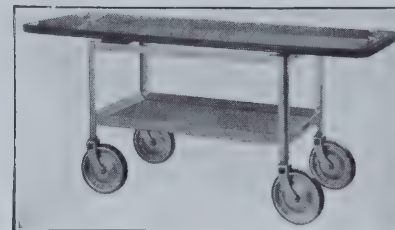
One hospital reporting the purchase of only four quarts of milk a month paid 9 $\frac{1}{2}$ cents a quart, while a hospital purchasing 1,620 quarts reported a price of 10 cents.

Other instances of low quantities and lower prices than paid by some users of large quantities brought out from Mr. Dinsmore, the statement that in numerous studies of unit costs he has invariably found that prices do not vary according to quantity in all cases, and that low prices are obtained directly in proportion to the interest and skill of the individual purchaser.

NEW HOSPITAL COUNCIL

The University Hospital Executives' Council recently was formed by executive officers of hospitals under university control. The officers for the first year are: president, Robert E. Neff, University of Iowa Hospital, Iowa City; vice-president, Dr. R. C. Buerki, Wisconsin General Hospital, Madison; treasurer, Dr. H. A. Haynes, University of Michigan Hospital, Ann Arbor; secretary, John C. Dinsmore, University Clinics, Chicago.

These times demand ability, experience and responsibility as great as this



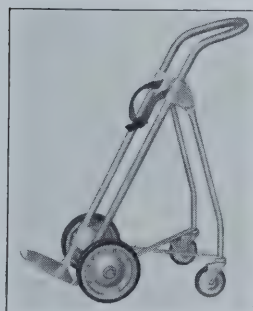
Above: Ideal wheeled stretcher—extremely light, rigid. Litter 11½" deep. Note handy blanket shelf.

Left: Ideal electric serving table (waterless). No installation expense.

Below: Ideal all-purpose operating table. All principal positions. Low priced.



Below: Ideal oxygen tank truck. Better balance, easier handling.



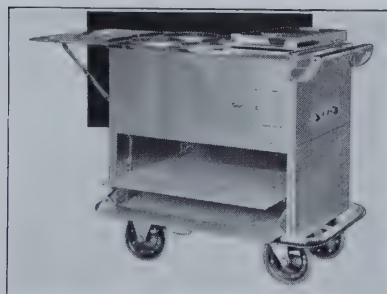
Below: Ideal tray carrier. Designed to minimize dish rattling.

NOW, especially, when every penny counts, is not the time to experiment with hospital equipment. Ideal equipment, food conveyors, trucks, operating tables are the products of engineering ability, long, practical experience and the co-operation of hospital authorities. They carry the guarantee of a well-established and financially sound manufacturer.

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Kitchen Trucks
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Laundry Trucks
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Rubber Bumpers



Left: Medium size indoor Ideal conveyor, enclosed type. Ideal conveyors are made in sizes and styles to fill the food distribution needs of any kind of hospital or institution. Keep food hot and appetizing. Eliminate mealtime noise and confusion. Cut food service costs.

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Many Factors Influence Service of Dietary Department

Here Are Some of the Things Expected of the Dietitian and Some of the Things She Ought to Expect, as Seen by One of Her Number

By HANNAH HOTVEDT

Dietitian, Corwin Hospital, Pueblo, Colo.

THE dietitian in a hospital plays the important role of food administrator. Her contacts are far reaching and her efficiency affects the efficiency of the hospital. Due to different associations, the term, "efficient dietitian," is interpreted differently by the various groups in the hospital, but should be considered from the standpoint of the hospital as a whole. The hospital superintendent often thinks of her in terms of dollars and cents, since she spends a large portion of the hospital dollar, or she is considered efficient if complaints are kept at a minimum. The patient remembers her in connection with his tray, or associates her with the proverbial spinach. The doctor thinks of her as the one who fills his dietary orders, and the nurses and employees in connection with the meals which they receive.

The dietitian's efficiency is larger in scope, however, and not determined by one or all of the above, but by the combination of various duties and responsibilities which make efficiency possible. Administration of a dietary department in all its phases requires efficiency. The duties will vary according to the size and type of hospital and the number of dietitians employed. This discussion will be limited to the efficient dietitian and her duties as they apply to the average size general hospital.

The object of the hospital in employing a dietitian is to direct the feeding of the patients and personnel. To accomplish this object the entire organization and management of the dietary department must function efficiently with the dietitian having complete control and full responsibility if she is to be efficient. It is incredible, however, to expect a young dietitian recently graduated to assume this great responsibility.

The dietitian's duties are largely

administrative, and her efficiency depends on her administrative ability. Even the application of her technical knowledge in diet therapy is futile if not efficiently handled in an administrative manner.

Menu planning is the keynote of the department and one of the most important duties. The efficient dietitian is not a faddist, but uses common sense and skill in applying her scientific knowledge. With the welfare and satisfaction of the patient uppermost in her mind, she plans menus to meet their dietetic requirements and makes adjustments to suit the individual whenever possible. The menu affects the health and contentment of the hospital family and she must meet their requirements as well. Upon the menu depends also the cost of the department with the following factors involved:

Market conditions, cost of foods—the menu should be adapted to changes in market conditions. The efficient dietitian will not insist upon including in her menus an item which at the time is exorbitant in price, when a substitute can be made, unless the welfare of the patient is at stake. Methods of purchasing, methods of handling, and methods of preparation involve points too numerous to discuss in this paper.

Quantity prepared—the dietitian must know number to be fed and must understand quantity cookery; the waste involved depends on purchasing and preparation. The dietitian must attempt to learn the general likes and dislikes or waste will be nutritional as well as material.

Methods of distribution and type of service vary in hospitals but greatly affect cost; type and amount of equipment, not only equipment in main kitchens, but also minor items such as dishes, must be considered, and lastly the number of employees.

The dietitian cannot ignore the above points, and efficiency demands

that she is ever alert in considering and improving any of these conditions to benefit the hospital, its patients and personnel.

The buying of food materials, the handling of food from source to finished product, are most important duties and give the dietitian the incentive necessary to keep within the budget allowance and yet maintain high food standards. The dietitian should be held strictly accountable for the expenses of the entire department, and, therefore, another duty assigned to her is that of cost accountant. A dietary budget or some definite method of controlling cost should be practiced, in order to secure the maximum efficiency. This budget should allow for a variation due to changing markets, type and number of patients, variety of illnesses, and the number and type of special diets as they affect food costs. The dietitian's aim in food costs should be the best menu of the best possible quality within the allowance made by the hospital.

The dietitian is responsible for all special diets. The efficient dietitian is well informed and willing to assist the doctors in working out new diets or adjusting diets to unusual situations. The greater the cooperation between doctors and the dietitian, the greater the benefit to both patient and hospital. This applies to routine diets as well as to special diets.

The dietitian is also a teacher. It is her duty to instruct patients regarding their diet. If a nurses' school is connected with the hospital, she must instruct students in the class room and in the diet kitchen. She must understand and instruct her employes in their duties; instruct the cooks in the preparation of food and quantity to be prepared. Her influence as a teacher is not limited to the hospital, as the information gathered by patients and employes through their association in the hos-

From a paper read before 1932 Colorado Hospital Association convention.

IF YOU SEE THIS MAN—Please treat him well!

He is an old friend of ours, and we will appreciate anything you can do for him!



THE amiable old gentleman pictured here is apt to show up at your institution some time on the evening of the twenty-fifth of December. He may have a slightly sprained wrist—the result of constant digging into his bag to pull out gifts for mankind. He is apt, also, to show the effects of numerous entrances through chimneys, with perhaps a bruise here and there, due to a faulty landing. If he should apply for treatment, may we ask you, on behalf of ourselves, to give him the best of first aid, to refresh his energies so that he may go forth to complete his errand.

P. S.—As he rests, serve him a cup or two of Continental Coffee.



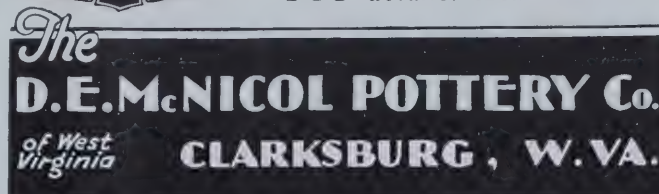
LOOK at your CHINA as your Patients do

IT is poor economy to continue to use chinaware after it has outlived its usefulness. It is not only a reflection on your institution, but it is a proved fact that people EAT LESS when the china service is scratched, cracked, chipped or discolored.

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pital is utilized by them in their homes.

The employing and supervising of employes in the dietary department is another duty of the dietitian. The efficient dietitian selects her employes carefully, keeps them contented, inspired, and encouraged, which results in an efficient, harmonious organization. She realizes the expense and inconvenience of labor turnover. This is of great importance, since it is actually the employes who handle the food, equipment, dishes, etc.

The efficient dietitian is a good housekeeper, inspecting closely her department and maintaining high standards of cleanliness. She must understand equipment, keep it in good condition by supervision, report repair work when needed, and recommend replacements. It is also her duty to know new modern types of dietary equipment, recommending it to the superintendent if she is convinced that it is beneficial either by reducing expenditure or improving service.

Problems connected with the purchasing, care, and replacement of linen, silver, dishes, and other accessories, must be solved by the dietitian. These also affect the cost of her department. The laundry must also be considered.

In order to be efficient and manage the dietary department in an efficient manner, the dietitian must have the utmost support and confidence of the superintendent. This is most essential in performing her duties, and assuming the responsibility. From the doctors she needs confidence, sympathy, and interest in her problems, from the superintendent of nurses and her staff the cooperation in every way, not only in problems connected with feeding the sick, but in all phases of hospital life. From her employes she demands and expects loyalty and respect, both personally and professionally. She is directly responsible for this. On the other hand, the efficient dietitian gives the utmost to her department and her interest, loyalty, and cooperation within the hospital.

The efficient dietitian is concerned with a multitude of duties, major and minor, the culmination of which makes an efficient dietary department which aids in serving the purpose of the hospital with the interest, welfare, and satisfaction of the patient paramount.

ENDS ALLOWANCE

Although the Montreal General Hospital had discontinued its former allowance of \$10 per month to student nurses, Dr. John C. MacKenzie, general superintendent, reports that in 1931 there were 403 applicants to the school.

Dietitians Have "Best Meeting" In New York City

WITH a registration of 1,300 and the largest exposition in its history, the American Dietetic Association reported its "best meeting" at Hotel Pennsylvania, New York, last month. The fact that both the attendance and the number of exhibitors surpassed previous marks was most gratifying to officers and members alike, especially in view of the fact that a number of associations have reported curtailed registration and exhibits this year.

The program as reported in HOSPITAL MANAGEMENT was given with very few changes and the emphasis on educational activities was pronounced throughout the week.

Dr. Martha Koehne, University of Michigan, was in the chair at the principal sessions of this record-breaking convention and turned over the responsibilities of the presidency to Dr. Kate Daum, University of Iowa, at the conclusion of the final session.

The other new officers of the association are:

President-elect: Quindara Oliver Dodge, Women's Industrial and Educational Union, and assistant professor, Simmons College, Boston.

Vice-presidents: Nelda Ross, Presbyterian Hospital, New York; Ruth Lsuby, Seattle, Wash.

Treasurer, Ella Eck, Billings Memorial Hospital, Chicago.

Secretary, Margaret Ritchie, Battle Creek College, Battle Creek, Mich.

Section chairmen:

Administration, Faith McAuley, University of Chicago, Chicago.

Diet therapy, Lute Trout, University of Indiana Hospitals, Indianapolis.

Community education: Laura Comstock, Eastman Kodak Company, Rochester, N. Y.

Professional Education, Mary M.

Harrington, Harper Hospital, Detroit.

It is to be noted that the activities heretofore carried out under the designation, "social service section" now will be conducted by the section of "community education."

As in past years, numerous breakfasts and luncheons and dinners of special groups were held, and news of the daily happenings were reported in an attractive bulletin. The social and recreational and sightseeing features of the convention also were handled in an unusually capable fashion and all who were present were highly pleased at the general success of the convention.

COUNTING MEALS

In a round table discussion of food costs and meal costs, one veteran superintendent wanted to know how many of those present counted actual meals or only multiplied by three the number of patients and personnel. There was the customary division, some visitors indicating they counted meals and others that they guessed at the number of meals by multiplying by three the hospital and personal census. The first speaker then asserted that a hospital which uses the census method of computing meals, that is, which multiplies the census by three, may be 15 per cent or more off. In other words, the census method assumes that every patient eats three meals, and does not take into account afternoons or other periods off by personnel, some of whom are not in the dining room for a given meal. Again, since babies are counted as patients, the census method credits each infant as consuming three meals. "So," concluded this superintendent, "the hospital that actually counts meals may be figuring its unit cost on a number of meals that is 15 per cent less than the number which would be arrived at by simply multiplying the census of the hospital patients and family by three. And consequently the accurate meal count would show a meal cost considerably higher than by the other method."

CLEVELAND HOUSEKEEPERS

The November meeting of the Cleveland Chapter, National Executive Housekeepers Association, was held at the Fenway Hall, with Mrs. Clara B. Hill as hostess. Mrs. C. E. Garthe, of Bolton Square Hotel, was appointed to serve on the national relations committee. Talks were given by W. F. Stein, F. Rupp, Mr. Nelson and John Hirsch, manager of Fenway Hall.

RADIOGRAPHERS' MEETING

The national convention of the American Society of Radiographers is to be held in Rochester, N. Y., May 31 to June 3, 1933. The program will present outstanding speakers. Hazel Englebrecht, Equitable Building, Des Moines, Ia., is chairman of the program and entertainment committee.





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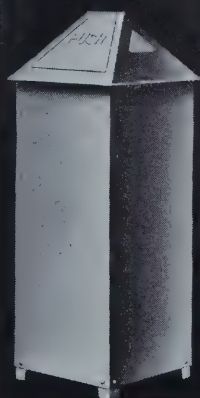
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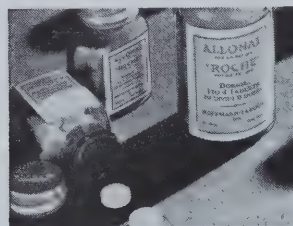
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The Record Department

Registry Announced By Record Librarians

By Edith M. Robbins

Record Librarian, Peter Bent Brigham Hospital, Boston, Chairman of Board of Registration, A. R. L. N. A.

THE Association of Record Librarians of North America is desirous of giving publicity to the registry for trained record librarians recently established.

A Registry for Record Librarians was established by the Association at its session in Detroit to fill a need long felt by record librarians and hospital superintendents. The Association provides for registration of properly trained librarians but refuses to act as an employment agency.

Record librarians, who are already active members in good standing in the Association of Record Librarians of North America may register without examination within one year after the establishment of the Registry. Newly trained record librarians may register after submitting evidence of proper character and passing an examination to be set by the Board of Registration. A certificate of registration will be issued to each approved candidate.

Record librarians are urged to communicate with the Registrar, Evelyn Vredenburg, Woman's Hospital, New York, N. Y., for full particulars.

Has Male Record Librarian

St. Louis City Hospital No. 1, V. Ray Alexander, superintendent, is unique in that the head of its record department is a man, Otto Ehlert, who has been in that department nearly ten years, and who has been in charge since September, 1931.

Some facts concerning the activities of this record department were prepared by Mr. Alexander in response to a recent inquiry, and they are summarized in the following:

The hospital cared for 22,404 in-patients in the year ending March 31, 1932, and 142,966 out-patients.

The personnel of the record department consists of three men and ten per cent of the time of Mr. Ehlert is consumed in presenting official records in court and before the Workmen's Compensation Commission as the result of subpoenas.

The department receives an average of eleven inquiries a day regarding patients' records, but the record room staff does not handle legal, social, or insurance matters.

The histories are filed according to diagnosis, the Bellevue Hospital's nomenclature being used.

PHILADELPHIA MEETING

The October meeting of the Philadelphia Hospital Record Librarians was held at Graduate Hospital. Due to an automobile accident, the secretary, Mrs. Higgins, was unable to be present. Best wishes for a speedy recovery were expressed. Miss Hanauer, Graduate Hospital, told of the meetings she attended at Detroit. She stated that the usual record problems such as "whether nurses' notes should be kept, why are there deficiencies in case records and how can they be rectified?" etc., were discussed again this year. Miss Hanauer's record librarian class is well known throughout the country and the Philadelphia organization was glad to meet the 16 members present at the meeting. Margaret N. Casey acted as secretary.

The November meeting was held at the Jewish Hospital. Seventeen hospitals were represented. Dr. Doane of the Jewish

Hospital gave a talk on the record librarian and records. He stated the librarian should try and approach the staff physician in the mornings, not at the end of a day when the doctors are tired. He also gave a very interesting talk on records; he stated that it would be very helpful if at some of the meetings we could have a pathologist, and have different kinds of specimens there and have the pathologist explain them.

CHICAGO MEETING

A meeting of the record Librarians of Chicago and Cook County was held at the Medical and Dental Arts Building, November 29, Effie M. Barnholdt presiding. The chief feature was a discourse on "The Blues" by Dr. Alex Hershfield, whose very able handling of the subject made it most interesting and enlightening. Dr. Hershfield was very glad to answer the many questions with which he was plying at the conclusion of the discourse.

A nominating committee was appointed. A round table discussion on the Standard Classified Nomenclature of Disease was led by Marguerite Simmons, Ravenswood Hospital. This being a new system, it was of much interest to all record librarians.

SASKATCHEWAN MEETING

The Saskatchewan Hospital Association held a very successful meeting at Moose Jaw, November 16 and 17. Speakers were Hon. F. D. Munroe, minister of public health; Dr. Malcolm T. MacEachern, American College of Surgeons; Dr. George F. Stephens, president, American Hospital Association; Leonard Shaw, superintendent, General Hospital, Moose Jaw; Dr. F. C. Middleton, provincial deputy minister of public health; Dr. R. A. Seymour, superintendent, City Hospital, Saskatoon; Dr. Vaughn E. Black, Moose Jaw General Hospital; R. T. Graham, chairman, board of governors, Swift Current Hospital, Swift Current; Dr. G. Harvey Agnew, secretary, hospital department, Canadian Medical Association; E. F. Webb, secretary-manager, Victoria Municipal Hospital, Prince Albert; G. E. Patterson, General Hospital, Regina; James Smith, chairman of finance, Moose Jaw General Hospital; B. J. McDaniel, solicitor, Rural Municipal Association, Saskatchewan; S. H. Curran, chairman of finance, Queen Victoria Hospital, Yorkton, and Dr. H. H. Mitchell, superintendent, General Hospital, Regina.

The following officers were elected: Mr. Shaw, reelected president; Dr. Seymour, first vice-president; Dr. Mitchell, second vice-president; Dr. R. G. Ferguson, director of sanatoriums, Fort Sanatorium, third vice-president, and Mr. Patterson, secretary-treasurer.

THE HOSPITAL CALENDAR

New England Hospital Association, Boston, Mass., Feb. 17-18, 1933.

Western Hospital Association, Long Beach, Calif., Feb. 22-25, 1933.

Hospital Association of Pennsylvania, Philadelphia, March 21-23, 1933.

Mississippi Hospital Association and Mississippi State Medical Association, Jackson, April 10, 1933.

Iowa Hospital Association, Marshalltown, April 19-20, 1933.

Illinois-Indiana-Wisconsin joint conference, Chicago, May 3-5, 1933.

American Society of Radiographers, Rochester, N. Y., May 31-June 3, 1933.

South Dakota Hospital Association, Sioux Falls, 1933.

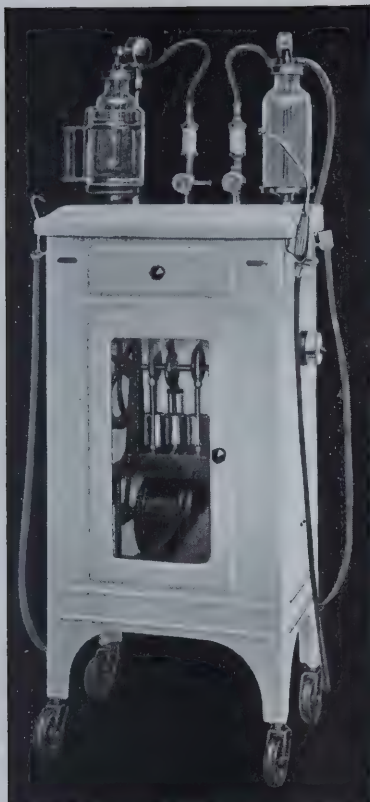
American Protestant Hospital Association, Milwaukee, Wisc., Sept. 8-9-10-11, 1933.

American Hospital Association, Milwaukee, Wis., September 11-15, 1933.

Association of Record Librarians of North America, Chicago, October 8-11, 1933.

American College of Surgeons, Chicago, October 8-11, 1933.

Biennial meeting, national nursing organizations, Washington, D. C., April 22-27, 1934.



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While the stories and legends of Florence Nightingale touch our hearts her true greatness is seen only when we place her against the background of heroic personalities that had preceded her. The far reaching influence of these figures and the movements they had launched can hardly be evaluated. But it was Florence Nightingale who wove the threads of Nursing into a composite, beautiful and effective pattern.

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The Nursing Department

Instructions for Making Occupied Bed

The instructions below are for students of the school of nursing of Columbia Hospital, Milwaukee, Wis., Earl R. Chandler, hospital superintendent, and are based on long study of routine in Massachusetts General; St. Luke's, New York; Johns Hopkins; Presbyterian, Chicago, and other hospitals. Other instructions in this school which relate closely to hospital economics will be published in later issues.

EQUIPMENT—

- 2 sheets
- 1 pillow case
- 1 spread (if needed)
- 1 nightgown
- Bathing solution
- Talcum powder
- Whisk broom

PROCEDURE—Arrange linen on table in order wanted. Change only such sheets as necessary. As a general rule, nurse begins on patient's right.

MAKING UPPER PART

Loosen upper bedding.

Remove spread, fold and hang on back of chair.

Remove all pillows but one and place on chair.

Remove soiled cases as necessary.

Remove all blankets but one and hang on back of chair. Turn remaining blanket and sheet back over the feet even with the foot of the bed and fold back upper part to waistline to facilitate removal. Place clean sheet over blanket, turn hem under in usual way. Take blanket from chair and place over clean sheet, both turned even with foot of bed.

REMOVAL OF SOILED UPPER BEDDING

If the patient's strength permits, he may hold upper edge of clean blanket and sheet, otherwise tuck over shoulders before removing soiled linen. Stand at foot of bed, raise clean sheet and blanket with left hand. With right hand remove soiled sheet and blanket with quick motion, catching them over right arm to prevent dragging on the floor. Spread blanket over chair, and if sheet is unsoiled, fold into draw sheet; otherwise put in pillow slip. Turn patient on left side by putting both hands under sacrum, and drawing patient toward you slowly turn on side. Position of patient should be hips drawn back and upper shoulder and knee forward for balance. Fold back upper bed clothing over patient, lengthwise, preparatory to

BATHING THE BACK

Unfasten nightgown. Holding bottle of bathing solution in right hand, remove cork with little finger of left. Bathe back with circular motion over prominent parts as shoulders, sacrum and coccyx. Apply powder.

If nightgown is to be changed, it should remain unbuttoned.

MAKING UNDER PART

Loosen each sheet separately, draw sheet first. Gather in small folds, beginning at center of bed, and press down as close to patient as possible; wedge under patient

with fingers held rigidly. Sweep off rubber sheet. Unfasten, turn down a corner at head and fold over patient. Unfasten under sheet and pass it under patient from head to foot. Sweep off mattress.

Place clean sheet on bed, doubled full length, right side up, selvage edge toward patient. Gather upper fold in both hands, starting with selvage edge (at the same time turning under fold out over edge of bed), and press under patient as far as possible; what is left is gathered in small folds close to the patient until the middle of sheet is reached, to be pulled through later when patient is turned over to opposite side of bed.

The remaining half of sheet is tucked in securely under mattress at head and corner made. Tuck under foot and along side.

Rubber sheet is now adjusted and its overhanging edge grasped in the middle with both hands, pulled tight and tucked in; then the top and bottom edges are tightened.

The folded draw sheet is placed in position over the rubber sheet, the upper selvage fold is brought over the edge of mattress and tucked in, the under selvage is pressed under patient as far as possible, and what is left gathered in small folds until the middle of draw sheet is reached, to be pulled through when patient is turned.

When the under sheets are not changed they are brushed free of crumbs and bed dust.

Support patient's head with one hand and with the other draw pillow to completed side of bed. Assist patient to move to completed side and adjust pillow comfortably under head.

Stepping to opposite side of bed, fold back upper bedclothes lengthwise over patient, avoiding exposure. Remove soiled draw sheet, fold in so that no bed dust escapes, and put in pillow slip. Pull through fresh cotton draw sheet and fold over patient in same way as rubber sheet.

Sweep off rubber sheet. Loosen and fold over patient. Gather up soiled under sheet and put in pillow slip. Sweep mattress. Pull through and adjust clean under sheet. Tuck in head and foot; pull and tighten middle. Tuck in and make corners. Tighten rubber sheet by grasping firmly and lifting upward while pulling, and tuck in. Adjust draw sheet and tuck in.

Support head and pull pillow to middle of bed. Turn patient on back. At this time, if patient has slipped down in bed, lift higher on pillow. Patient may help by flexing knees and pressing soles of feet on bed and grasping rung of bed with both hands.

CHANGING NIGHTGOWN

Turn bed clothes to waist. Pull nightgown from each side of body carefully. The change from soiled to clean gown is made one arm at a time. Place hand in arm-hole of sleeve and grasping patient's elbow, with other hand remove sleeve. Put down arm gently. Clean nightgown is placed over soiled one. Introducing hand into sleeve, grasp patient's hand and draw his arm into sleeve. See that gown fits well over shoulders. Fasten at neck; with very sick patient it is not essential to fasten all the way down. Slip out soiled gown. Adjust shoulder seam to prevent binding arms.

ARRANGEMENT OF PILLOWS

The pillow under patient's head is now removed. Collapse pillows from each end to bring feathers to center.

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FINAL ARRANGEMENT OF UPPER BEDCLOTHING

Make sure that bedclothing is well up under chin and over shoulders. Tuck upper sheet under mattress at the foot. In making corners a plait is taken at both sides to prevent pressure over toes. Put on second blanket; tuck in both, making same plait while turning corners. Sheet and blankets are tucked on both sides as far as the patient's knees, not above.

Put on spread evenly; arrange evenly with blankets at top, or if long enough, turn over blankets. Tuck under mattress at foot and make corners. Top of sheet is turned out over spread. Center of sheet should meet center of spread.

If the patient wishes arms outside of bed covers, make an additional fold of the upper bedclothing upon itself as far as arm spaces. Suit patient's comfort as far as possible.

BEDSIDE ADJUSTMENT

Replace table, inspect drawer and replace chair. Take away equipment. Leave bedside in order.

UNIVERSITY DEPARTMENT

A new circular of the department of nursing of DePaul University, Chicago, serves to recall that this department has been in existence since 1926, under the supervision of Joseph A. Tobin, A. B., M. D., M. A. The departmental staff is headed by Sister Mary Vincent, R. N., B. S., director of nursing education, St. Joseph's Hospital, Chicago, who holds a professorship in nursing education. Sister Magdalene, R. N., Ph. B., director of nursing education, St. John's Hospital, Springfield, Ill., and of the schools of nursing conducted by the Hospital Sisters of St. Francis, also is a professor of nursing education in the department. Special lecturers in the department are Edna L. Foley, R. N., B. L., D. Sc., superintendent of the Visiting Nursing Association, Chicago; M. T. MacEachern, M. D., C. M., D. Sc.; Sister Mary Therese, R. N., B. S., M. A., educational director, John B. Murphy Hospital, Chicago; Dr. Tobin, university director and supervisor of the department, and Gladys Sellow, R. N., B. S., M. A., director of nursing education, St. Vincent's Infant Asylum, Chicago.

Seven schools of nursing are affiliated with the University, and the course also is open to graduate nurses holding an R. N. from a nursing school of approved standing. For information address Dr. Joseph A. Tobin, 64 East Lake street, Chicago.

NEW HOSPITAL GROUP

The Association of Private Hospitals of Greater New York was organized November 15 at the New York Physician's Club. Representatives of 17 private hospitals which had been invited to join were present and agreed to sign a pledge to improve the scientific efficiency of their hospitals, to abolish fee-splitting and to rule against commissions being paid to physicians patronizing their hospitals. An attempt will be made later on to standardize smaller non-member institutions and thus enable them to give better service. The following private hospitals were represented: Adelphi Sanitarium, Brooklyn; Boulevard Hospital, Astoria; Crown Heights Hospital, Brooklyn; Fitch Sanitarium, Bronx; Madison Hospital, New York; Madison Park Hospital, Brooklyn; Manhattan General Hospital, New York; Midwood Sanitarium, Brooklyn; Mount Morris Park Hospital, New York; Murray Hill Hospital, New York; Park East Hospital, New York; Park West Hospital, New York; Shore Road Hospital, Brooklyn; University Heights Hospital, Bronx; Wadsworth Hospital, New York; Westchester Square Hospital, Bronx; Wickersham Hospital, New York.

The following officers were elected: Dr. Harold Hays, president; vice-presidents—Dr. Charles W. Fitch, president, Fitch Sanitarium; Dr. Albert R. Fritz, president, Madison Park Hospital; Dr. Philip Schoenveld, president, Boulevard Hospital, and Dr. G. E. Browning, president, Wickersham Hospital, secretary-treasurer. Oscar R. Gottfried, who was instrumental in organizing the Association, was elected executive director. The offices of the Association are at 256 Fifth Avenue.

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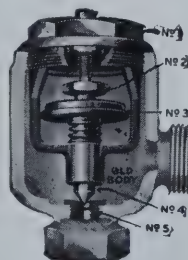
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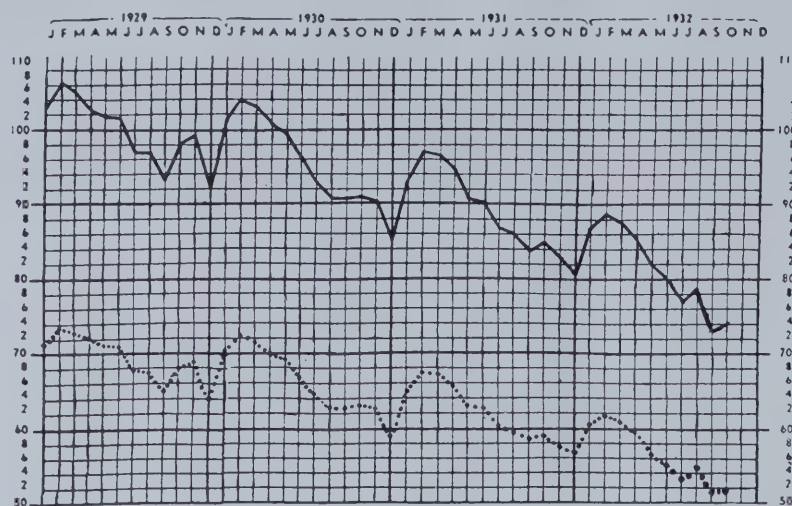
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HOW'S BUSINESS?

A composite picture of the percentage of occupancy in 91 general hospitals located in 87 communities in 35 states, corrected for normal growth.



The heavy line shows the occupancy of hospitals, based on the average occupancy of 1929 as 100 per cent. The dotted line shows the actual occupancy, based on the total bed capacity of the hospitals participating in this monthly survey. During September* and October* one reporting hospital had no patients, and reported no income or expense because of closing down as part of a building program.

Here Are Figures From Which Occupancy Chart Was Constructed

THE following figures are the basis of the hospital occupancy chart reproduced at the top of this page. These figures were supplied by 91 general hospitals in 87 communities of 35 states, with a basic bed capacity of 16,922.

The first group of figures represents actual number of beds occupied; the second group, receipts from patients; the third, operating expenses and the fourth, occupancy.

TOTAL DAILY AVERAGE PATIENT CENSUS

November, 1928	11,533
December, 1928	11,040
January, 1929	11,919
February, 1929	12,335
March, 1929	12,253
April, 1929	12,114
May, 1929	11,981
June, 1929	12,025
July, 1929	11,473
August, 1929	11,548
September, 1929	11,157
October, 1929	11,590
November, 1929	11,736
December, 1929	10,977
January, 1930	12,048
February, 1930	12,425
March, 1930	12,408
April, 1930	12,128
May, 1930	12,044
June, 1930	11,601
July, 1930	11,290
August, 1930	10,997
September, 1930	11,015
October, 1930	11,086
November, 1930	11,005
December, 1930	10,524
January, 1931	11,510
February, 1931	11,991
March, 1931	11,970
April, 1931	11,669

May, 1931	11,251
June, 1931	11,187
July, 1931	10,765
August, 1931	10,657
September, 1931	10,409
October, 1931	10,499
November, 1931	10,266
December, 1931	10,145
January, 1932	10,758
February, 1932	11,038
March, 1932	10,888
April, 1932	10,596
May, 1932	10,082
June, 1932	9,927
July, 1932	9,571
August, 1932	9,748
*September, 1932	9,125
*October, 1932	9,226

RECEIPTS FROM PATIENTS

November, 1928	\$1,678,735.00
December, 1928	1,736,302.86
January, 1929	1,795,843.79
February, 1929	1,776,040.82
March, 1929	2,024,823.11
April, 1929	1,929,175.70
May, 1929	1,920,982.43
June, 1929	1,874,173.11
July, 1929	1,846,899.32
August, 1929	1,867,706.24
September, 1929	1,772,230.39
October, 1929	1,828,051.39
November, 1929	1,786,036.71
December, 1929	1,737,404.65
January, 1930	1,840,418.05
February, 1930	1,799,080.00
March, 1930	2,003,309.58
April, 1930	1,927,493.30
May, 1930	1,921,523.05
June, 1930	1,817,813.00
July, 1930	1,803,315.00
August, 1930	1,719,634.00
September, 1930	1,700,314.00
October, 1930	1,741,017.00
November, 1930	1,640,374.00
December, 1930	1,687,813.00
January, 1931	1,771,812.00
February, 1931	1,720,474.00
March, 1931	1,881,003.00
April, 1931	1,831,228.00
May, 1931	1,815,096.00
June, 1931	1,743,189.00
July, 1931	1,698,277.00

August, 1931	1,598,869.00
September, 1931	1,555,436.00
October, 1931	1,583,005.00
November, 1931	1,497,948.00
December, 1931	1,521,552.00
January, 1932	1,527,159.00
February, 1932	1,468,059.00
March, 1932	1,574,446.00
April, 1932	1,496,077.00
May, 1932	1,453,746.00
June, 1932	1,417,856.00
July, 1932	1,357,096.00
August, 1932	1,327,016.00
September, 1932	1,244,635.00
*October, 1932	1,248,504.00

OPERATING EXPENDITURES

November, 1928	\$1,936,075.00
December, 1928	2,064,632.41
January, 1929	2,104,552.74
February, 1929	2,007,945.24
March, 1929	2,099,208.11
April, 1929	2,071,386.46
May, 1929	2,064,381.77
June, 1929	2,034,409.13
July, 1929	2,045,112.96
August, 1929	2,068,388.63
September, 1929	2,050,510.38
October, 1929	2,079,042.06
November, 1929	2,091,089.31
December, 1929	2,127,053.36
January, 1930	2,190,909.95
February, 1930	2,067,112.17
March, 1930	2,120,861.86
April, 1930	2,064,328.56
May, 1930	2,102,407.49
June, 1930	2,027,258.00
July, 1930	2,038,042.00
August, 1930	1,985,045.00
September, 1930	2,079,154.00
October, 1930	2,033,163.00
November, 1930	2,003,297.00
December, 1930	2,031,148.00
January, 1931	2,058,681.00
February, 1931	1,963,391.00
March, 1931	2,026,363.00
April, 1931	1,976,430.00
May, 1931	1,967,866.00
June, 1931	1,932,832.00
July, 1931	1,925,156.00
August, 1931	1,870,985.00
September, 1931	1,890,891.00
October, 1931	1,885,424.00
November, 1931	1,829,539.00
December, 1931	1,889,887.00
January, 1932	1,806,279.00
February, 1932	1,763,572.00
March, 1932	1,762,657.00
April, 1932	1,733,486.00
May, 1932	1,672,550.00
June, 1932	1,607,822.00
July, 1932	1,590,274.00
August, 1932	1,565,767.00
*September, 1932	1,508,519.00
*October, 1932	1,515,582.00

AVERAGE OCCUPANCY ON 100 PER CENT BASIS

November, 1928	69.6
December, 1928	66.5
January, 1929	71.6
February, 1929	73.8
March, 1929	73.2
April, 1929	72.2
May, 1929	71.2
June, 1929	71.3
July, 1929	67.8
August, 1929	67.5
September, 1929	65.0
October, 1929	68.0
November, 1929	68.6
December, 1929	64.0
January, 1930	70.1
February, 1930	72.1
March, 1930	71.8
April, 1930	70.0
May, 1930	69.4
June, 1930	66.6
July, 1930	64.7
August, 1930	62.7
September, 1930	62.8
October, 1930	62.9
November, 1930	62.4
December, 1930	59.1
January, 1931	64.9
February, 1931	67.5
March, 1931	67.2
April, 1931	65.8
May, 1931	63.0
June, 1931	62.6
July, 1931	60.3
August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.5
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	55.6
July, 1932	53.6
August, 1932	54.6
*September, 1932	51.1
*October, 1932	51.6

CLASSIFIED ADVERTISEMENTS

Use this department to secure employment, fill positions which are open, buy or sell commodities or service, etc., etc.

Rates are eight cents per word per insertion. If copy is repeated without change in three consecutive issues the total charge is twice the charge for a single insertion. Instructions to print classified advertisements should be accompanied by

check, money order, or cash in full payment.

If desired, inquiries will be received under a box number at this office and forwarded to the advertiser without extra charge. Count four words for box number.

Additional charge is made for special arrangement of type or unusual set-ups.

FOR SALE

RADIUM BOUGHT, SOLD AND PREPARATIONS made to order; also a supervised Radium Rental Service. Quincy X-Ray-Radium Laboratories, Quincy, Ill. 1232

DIPLOMAS—ONE OR A THOUSAND. ILLUSTRATED circular mailed on request. Ames & Rollinson, 206 Broadway, New York City. tf

POSITIONS OPEN

AZNOE'S CENTRAL REGISTRY

Ermina M. Bates, Director

30 North Michigan Ave., Chicago

NURSE EXECUTIVES WANTED: (a) Approved hospital south needs Superintendent of Nurses; must give gas and ether; small training school. (b) Superintendent of 50-bed general hospital open; state salary desired. Vicinity large southern city. No. 5092

INSTRUCTORS NEEDED: (a) Large hospital in southern metropolis offers \$100, maintenance for instructor; report January 1st. (b) College trained instructor wanted, hospital located suburb, large midwestern city. \$135, maintenance. Report February. No. 5093

SUPERVISORS: (a) East coast hospital wants operating room supervisor; \$100 maintenance. (b) Surgical nurse-Anesthetist (Heidbrink machine) for northern hospital; no training school. Salary open. (c) Birth-room supervisor, nationally known maternity hospital; Chicago Lying-In training essential. (d) Night supervisor, small Wisconsin hospital. (e) Operating room nurse, small approved hospital southwest; graduate nurse staff. Salary open. No. 5094

NURSE-LABORATORIAN: (a) Illinois hospital needs nurse-laboratorian able to operate Gwathmey gas machine; \$125 maintenance to start. (b) New York physician needs office nurse; must operate X-ray machine and keep books. (c) Florida hospital, graduate staff, wants laboratorian anesthetist. Good salary. (d) Nurse-laboratorian experienced in tuberculosis work needed, central location. \$90, maintenance. No. 5095

LABORATORIAN-X-RAY TECHNICIAN wanted for good-sized eastern hospital; excellent living quarters; attractive salary. Only experienced woman living in the east considered. No. 5096

POSITIONS OPEN

INTERSTATE PHYSICIANS & HOSPITAL BUREAU

332 Bulkley Bldg.
Cleveland, O.

INSTRUCTOR THEORY AND PRACTICE: B. S. Degree, one year teaching experience. 100-bed hospital, 40 students. Mid-western state. Salary \$135. Open February.

PRACTICAL INSTRUCTOR: Central New York hospital. Requirements: One year college; New York registration. Open January.

MEDICAL BUREAU

M. Burneice Larson, Director
Pittsfield Bldg., Chicago, Ill.

The Medical Bureau is organized to assist physicians, dentists, graduate nurses, hospital executives, laboratory technicians and dietitians in securing positions; application on request. The Medical Bureau (M. Burneice Larson, Director), 3800 Pittsfield Bldg., Chicago. tf

POSITIONS WANTED

NORTH'S HOSPITAL REGISTRY

403 Madison Street
Yazoo City, Mississippi

Why worry when an unexpected vacancy occurs in your personnel? We have a very complete list of hospital executives and workers, thoroughly qualified by training and experience, and are ready to give your calls immediate and courteous attention. There is no charge to the employer. Write or wire us.

EXPERIENCED INSTRUCTOR WITH COLLEGE degree available immediately; graduate large school. Will consider any location. Address Hospital Management, Box 509.

RECORD LIBRARIAN—GRADUATE LIBRARY science five years technical reference library; eight years 400-bed hospital; installed record systems. Address Box 501, Hospital Management. 1232

NURSE EXECUTIVE WITH FOUR YEARS' EXPERIENCE as Assistant Director large school of nursing; 18 months as Directress of Nurses leading hospital, and experience managing small hospital wants Superintendency or Directorship of training school. Rural location preferred. Address Hospital Management, Box 512.

POSITIONS WANTED

ALLIED PROFESSIONAL BUREAU

M. Scallon, Director

742 Marshall Field Annex Bldg.
Chicago, Ill.

Let us recommend thoroughly qualified personnel for your hospital. Write us immediately if you need experienced executives, supervisors, nurses, technicians or dietitians. tf

MEDICAL BUREAU

M. Burneice Larson, Director
Pittsfield Bldg., Chicago, Ill.

The Medical Bureau has available for appointments a great group of physicians, dentists, hospital executives, graduate nurses, laboratory technicians and dietitians. All credentials have been painstakingly investigated. If you have vacancies on your medical or nursing staffs, write for biographies of qualified applicants. The Medical Bureau (M. Burneice Larson, Director), 3800 Pittsfield Bldg., Chicago. tf

WANTED: POSITION AS ANESTHETIST BY registered nurse trained Lakeside Hospital, Cleveland. Experience includes night and obstetrical supervising in addition to anesthesia; will combine duties. Best of references. Address Hospital Management, Box 510.

PEDIATRIC OR OBSTETRICAL SUPERVISING wanted: Have 10 months' special training and good experience. Registered Minnesota; will go anywhere. Low salary. Address Hospital Management, Box 511.

ZINSER PERSONNEL SERVICE

Anne V. Zinser, Director
1547 Marquette Bldg.
Chicago, Ill.

Zinser Personnel Service offers a selective service to hospitals seeking qualified graduate nurses, supervisors, instructors, superintendents, dietitians, anesthetists, technicians, physicians.

AZNOE'S CENTRAL REGISTRY

30 North Michigan Avenue,
Chicago, Illinois.

NURSES, DIETITIANS, TECHNICIANS, PHYSICIANS furnished to first-class institutions. Prompt reliable service. Candidates' credentials including photographs on file. List your vacancies by letter or collect wire. tf

Classified Advertisements

cost only 8 cents a word—

use them for best results

Need Help With Collections?

Here's a convenient, low-cost method that will help you with collections and other matters relating to cooperation of patients, visitors and the public.

“Hospitals must adopt a plan of public education. They must utilize every possible means of disseminating information about themselves,” says the 1932 A. H. A. report on public relations.

Instead of a mere statement of amount due, or a collection letter, why not enclose with your bills, a friendly, newsy pamphlet that is sure to be read by every former patient? Some thing that will give them reasons why the hospital needs money and why they should make as large a payment as possible now, if they can not pay in full?

As an aid to collections a hospital bulletin will pay for itself alone, but that's just one of the many things that a bulletin will do for you.

You'll be surprised at the cost, even when compared with 1932 prices.

A post card request will bring information fitted to your own problems.



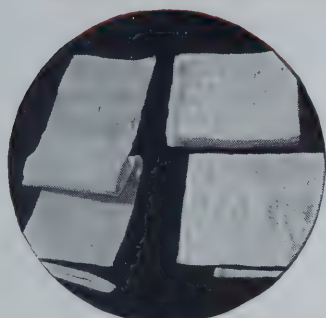
HOSPITAL MANAGEMENT

537 So. Dearborn Street

Chicago, Illinois

BANISHED!

PLASTER ROOM NUISANCES...



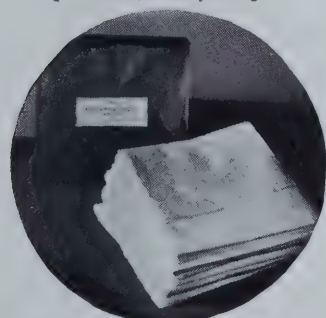
A. B. D. FLAT PACKS

Smooth, quickly absorbent. Even cross stitches and well-bound seams. Large tape loops.



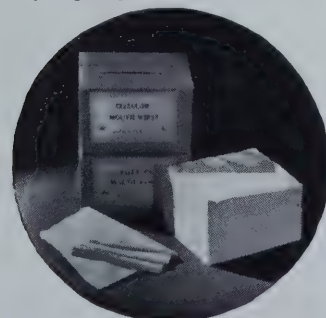
NU-GAUZE STRIPS

Non-raveling selvage edges. Sterile, in bottles—plain or with Iodoform 5%; unsterile, plain, bulk, in 100-yd. lengths.



BELLEVIEW SURGICAL WADDING

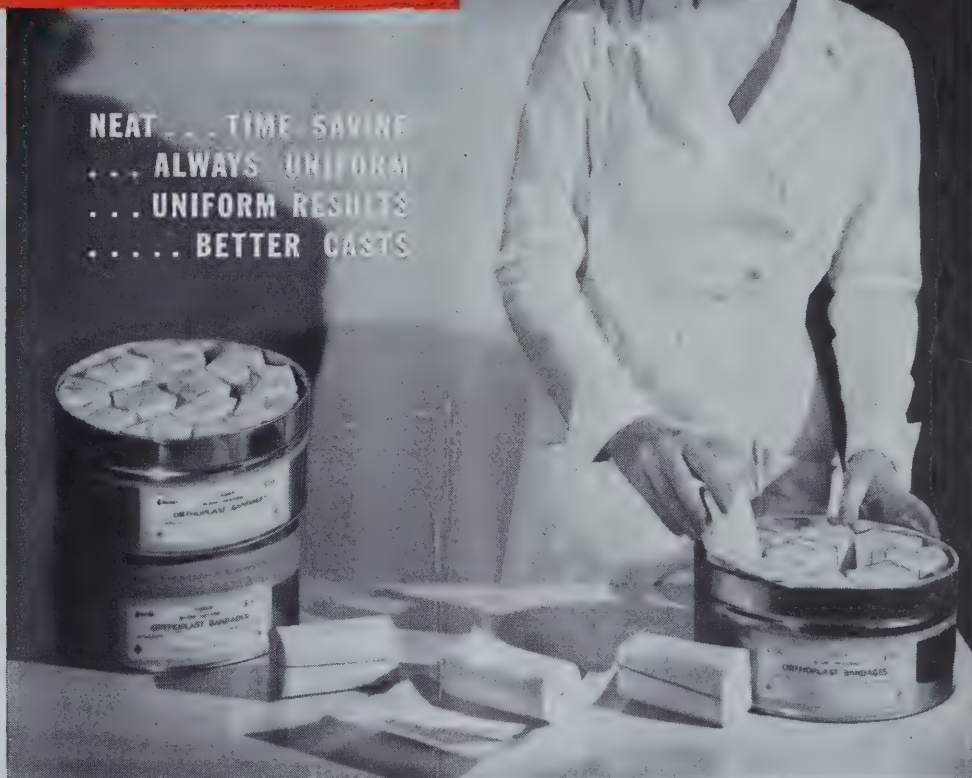
Soft, non-absorbent cotton padding, used under plaster bandages. In sheets 36" x 6 yds.; packages of 6, 40 and 80 sheets.



CELLULOSE MOUTH WIPES

In boxes of 400 sheets, 5" x 6", 72 boxes in a case.

NEAT... TIME SAVING
... ALWAYS UNIFORM
... UNIFORM RESULTS
..... BETTER CASTS



When you use ORTHOPLAST

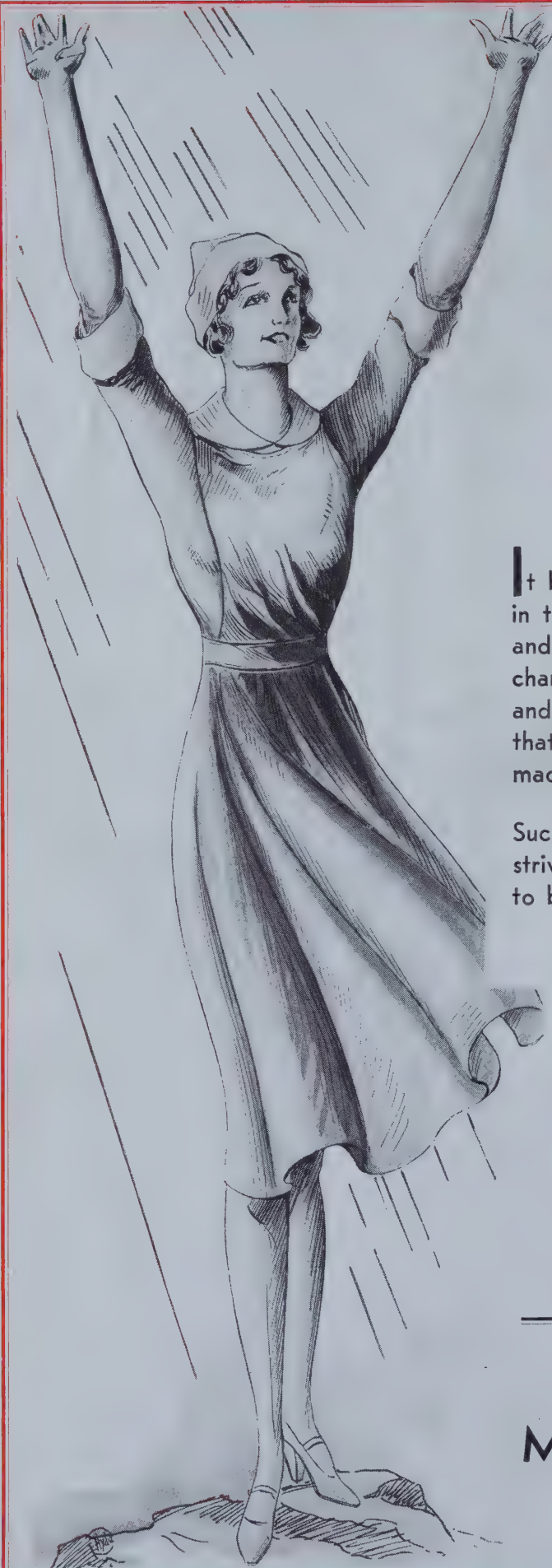
Plaster room uncertainties—of personnel and product—are eliminated when you adopt Orthoplast Bandages, now used by Bellevue Hospital, New York, and many other large institutions. Orthoplast Bandages are uniformly made to give uniform results. Made with specially-refined plaster of Paris, pressed smoothly with scientific exactness into Red Cross surgical crinoline by machine. Serrated edges prevent raveling and tangling threads that hinder application. Completely saturated in less than a minute. Orthoplast Bandages have a definite setting time—fast setting, 3 to 6 minutes; slow setting, 10 to 18 minutes. In 3-yd. lengths, 2" and 3" widths; 5-yd. lengths, 4", 5", 6", 8", 10" widths. Trial box of Orthoplast Bandages gladly sent on request.

HOSPITAL DIVISION



Johnson & Johnson
NEW BRUNSWICK NEW JERSEY





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It brings to mind self sacrifice and heroic deeds in the relief of suffering, upon grimy battlefields and in the silence of the sickroom—courageous character, exemplified by Florence Nightingale and Edith Cavell. It is the symbol of a profession that carries on though the rest of the world goes mad.

Such a symbol must aim at perfection. And, in striving for that ideal, there is romance for us—to build the perfect uniform which will contribute its humble part in individual and institutional success.

Thousands of hospitals are regular users of Marvin-Neitzel uniforms. Many more are not. If you are of the latter, won't you do yourself, and us, the favor of investigating just how near we approach perfection in uniforms?

Just a word from you will bring complete information.



Established 1845

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TROY, N. Y.

ORIGINATORS OF SANFORIZED-SHRUNK UNIFORMS

Hospital Management

*A Practical Journal
of Administration*

VOLUME XXXIV—NUMBER 5



NOVEMBER 15, 1932

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Hospital laundries using Wyandotte Yellow Hoop find that their linens last longer. Wyandotte does not generate heat and consequently cannot harm the fibres.

Laundry washed with Wyandotte Yellow Hoop is more sanitary, looks better, wears longer, and costs less to wash.

Wyandotte Service Men in 88 North American cities will be glad to demonstrate these facts.



***Order from your Supply
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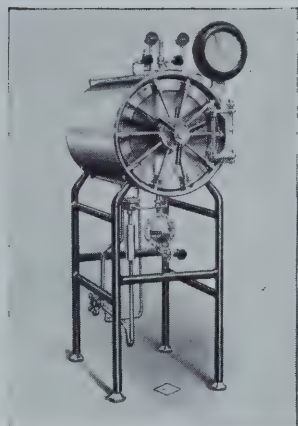
Wyandotte, Michigan

Wyandotte
Washes Clean
Yellow Hoop

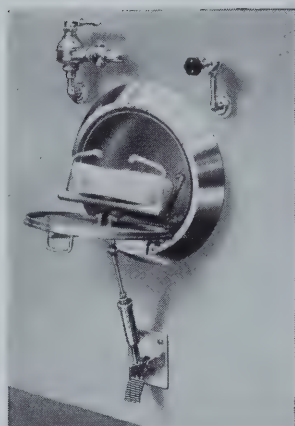
CONCERNING VALUE

Shall it be UP to Quality ?

Shall it be DOWN to Price ?



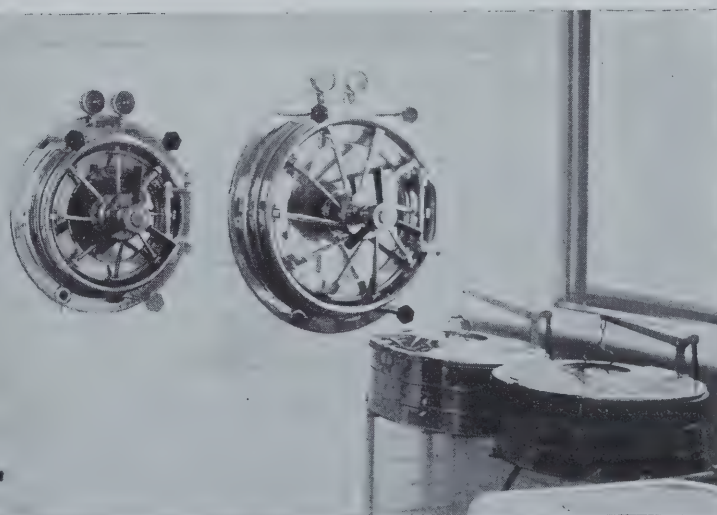
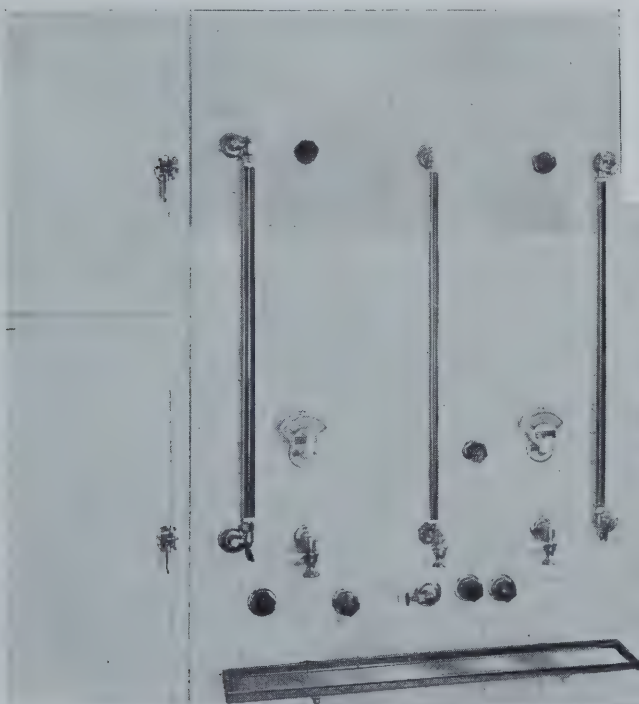
The improved Castle Autoclave with Two Pressure Automatic Control, Recording Gauge and Safety Adjustable Door.



“Regal” Built-in Bed Pan and Urinal Washer and Sterilizer. It does its work easily and positively.

Quality is the outstanding character of Castle Sterilizing Equipment. The price is based on how good we can make it. This reversal of the all too prevalent policy of building down to a price accounts for Castle installations in hospitals where compromise with quality is not tolerated. The fact is that Castle Sterilizers are selected more often than not where price competition is the keenest. When you insist on Castle you pay no premium for getting the best.

A line to the Wilmot Castle Co., 1154 University Ave., Rochester, N. Y. will bring you full data.



CASTLE STERILIZERS



AN EASY WAY TO BUILD GOOD WILL!

Supply your patients with the beauty soap they expect... the one they are sure of.

To keep skin youthful, vibrant!
this much OLIVE OIL goes into every 10c cake of Palmolive

NOW you can see exactly why women, your patients, are sure of Palmolive—why they expect this soap in your hospital. Glance at the test tube on the right. In it is Palmolive's great beauty ingredient—the lavish amount of Olive Oil that goes into every 10c cake.

This is why more than 20,000 beauty specialists say—to keep skin firm, youthful, radiant—use Palmolive. It is why more women prefer and use Palmolive than any other soap. *To you it means just this:* Palmolive in your hospital shows women you are considerate of their

beauty needs. You build good will—without effort, without additional expense.

In spite of its quality and prestige, Palmolive costs no more than ordinary soaps. Your hospital's name printed on the wrappers with orders of 1,000 cakes or more. Mail the coupon below today for our new free building cleanliness booklet and prices of Palmolive Soap in the five special sizes for hospitals.

An Actual Photograph

Palmolive contains only vegetable oils—no artificial coloring. Photo shows actual amount of olive oil that goes into each 10c cake.



SPECIAL ATTENTION LABORATORY TECHNICIANS **SUPER SUDS** for hospital laboratory use

Letters from hospital laboratory directors and technicians prove this new bead soap ideal to clean laboratory glassware, hospital instruments, utensils and equipment. *Super Suds* cleans quickly, easily, efficiently. It leaves bottles, slides, everything, bright, clean, sparkling! Mail coupon for complete information.

COLGATE-PALMOLIVE-PEET COMPANY,
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- ☐ Without obligation send me your free booklet, **BUILDING CLEANLINESS MAINTENANCE**—together with Palmolive Soap prices.
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COLGATE-PALMOLIVE-PEET COMPANY, Palmolive Building, Chicago
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HOSPITAL MANAGEMENT

A PRACTICAL JOURNAL OF ADMINISTRATION

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HOSPITAL MANAGEMENT for November, 1932

3

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Lewis Mfg. Co.
Will Ross, Inc.

ABSORBENT COTTON

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Johnson & Johnson
Lewis Mfg. Co.

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Davis & Geck, Inc.
Johnson & Johnson
Lewis Mfg. Co.
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Stanley Supply Co.

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Lehn & Fink, Inc.
John Sexton & Co.

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John Sexton & Co.

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John Sexton & Co.
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John Sexton & Co.

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FLOORING

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SnowWhite Garment Mfg. Co.
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NICKEL WARE

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Will Ross, Inc.
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* * *

The Spencer Automatic Laboratory Microtome No. 880 is popular for hospital work for one definite reason—namely, sections can be cut, stained and mounted in one and one-half minutes from the time the tissue is placed on the freezing plate. Page 55.

* * *

Day and night thermostats, clocks and switches may be arranged in a wide variety of combinations for the control of branch heating mains serving various sections of the building. Differential thermostats are available to maintain proper relationship between outdoor and radiator temperatures. Page 47.

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Do not accept without test any substitute offered in place of time-tried Diack controls. It is dangerous. Try the substitute for your usual sterilizing period at five pounds' pressure, which you know will not result in effective sterilization. Page 59.

* * *

It simplifies your problem to be able to obtain everything in hospital apparel from one source of supply. It doubly simplifies it, knowing that you can rely upon the dependable quality which flows from this source—a recognition that has been established during a period as old as modern hospitalization itself. Page 59.

* * *

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* * *

The life and appearance of hos-

These pithy paragraphs of practical and pertinent information concerning supplies and equipment are typical of the kind of information manufacturers and sales organizations offer readers of "Hospital Management" in every issue. Experienced hospital executives make it a point to read advertising pages carefully, too, and to keep in touch with new ideas and improvements in equipment and supplies as well as in methods of hospital administration. Every issue contains information as interesting and helpful as the paragraphs on this page, chosen at random from this month's advertisements.

pital linens and uniforms depend to a great extent on the use of the proper laundry soda. Hospital laundries using Wyandotte Yellow Hoop find that their linens last longer. Wyandotte does not generate heat and consequently cannot harm the fibres. Page 13.

* * *

Only the uncanny skill which comes with years of devotion to a single goal could account for the unvarying quality of the famous Continental blend. That goal is the production of a coffee designed to meet—perfectly—the requirements of hospitals, institutions and clubs. Your patients will detect the finer flavor of Continental—your staff will appreciate it, too. Page 57.

* * *

Sixty-three per cent of all hospitals in the United States are using standardized record forms from our American College of Surgeons, American Hospital Association, PR and Ponton Series. Training schools depend upon us for the official records approved by New York, North Carolina, Virginia, Ohio, and other state boards. Page 57.

* * *

Quality is the outstanding character of Castle Sterilizing Equipment. The price is based on how good we can make it. This reversal of the all too prevalent policy of building down to a price accounts for Castle installations in hospitals where compromise with quality is not tolerated. Page 1.

Drybak can be used in the innumerable cases in which washing has been avoided because of the possibility of loosening the adhesive plaster on dressings. Water will not pass through the Drybak fabric to separate the adhesive from the backcloth. The edges of Drybak will not turn up after washing. When the plaster is removed there is practically no residue left on the skin. Page 30.

* * *

Nurses report that Miller Anode gloves stand up under sterilization and last about twice as long as ordinary surgeons' gloves. In operating rooms where surgeons' gloves used to be discarded after three wearings, Anode gloves are now used six times and more, with absolute safety. Page 16.

* * *

The rugged construction of every Colt Autosan model means years of extra wear—and just so many dollars saved for you. And that rugged Colt Autosan construction insures you against breakdowns—cuts down upkeep costs—and practically eliminates repair bills. A user reports a total repair cost of just \$1.75 in six years. That's what we call real economy! Page 55.

* * *

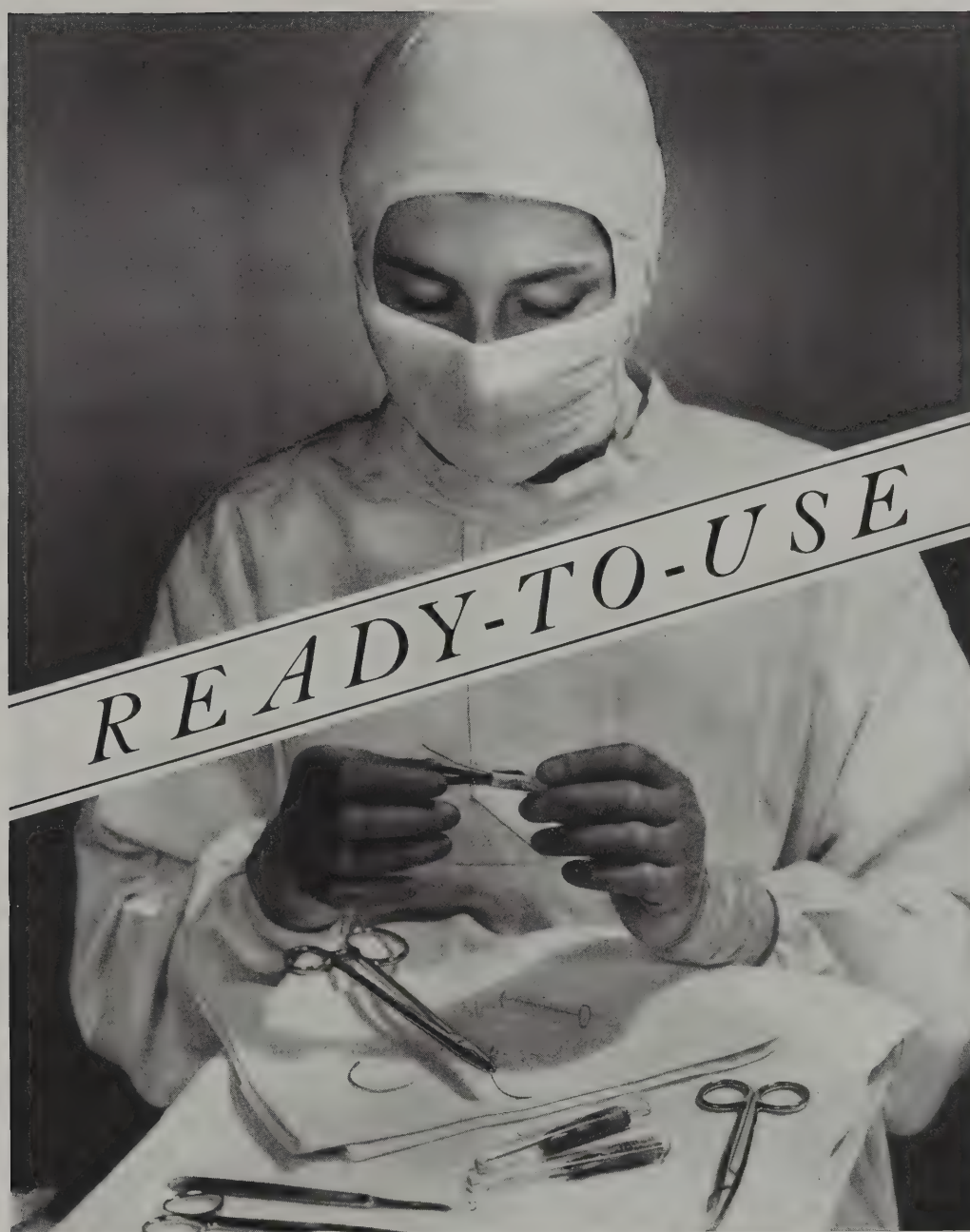
All the tangy deliciousness of pure, vitamin-rich oranges gives Gumpert's orange gelatine dessert its true orange flavor. Blended of the finest, purest ingredients, Gumpert quality is the choice wherever institutions select gelatine desserts on the basis of genuine quality rather than price alone. By choosing these Gumpert favorites you assure yourself of the appreciation and approval of your patients—good will that means far more than the slight additional price you pay for this superior quality. Fourth cover.

* * *

The greatly enlarged line of Ideal hospital equipment has many new items. But each one is the result only of careful design and engineering practice coupled with the co-operation of surgeons, superintendents, dietitians, and other experienced hospital executives. Then before being offered to the hospital field each item is thoroughly tested in actual use. Page 49.

* * *

The Solar equipped washroom is always spic and span. Here is but one of the many places where Solars guard against disease. Full details on the Solar System of waste disposal will be mailed upon request. Page 55.



NON-BOILABLE D & G Kalmerid Sutures are ready for immediate use as they come from the tubes. Their extreme flexibility makes moistening or special preparation unnecessary. Both the Non-Boilable and Boilable varieties are strong, smooth, accurate in size, and physiologically bland. *They are heat sterilized.*

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for a large twisted teratoma of the right ovary the size of a full term pregnant uterus—with chronic appendicitis. The gross and microscopic pathology reveals cysts and solid tumors containing skin, connective tissue, hair, cartilage, and bone.

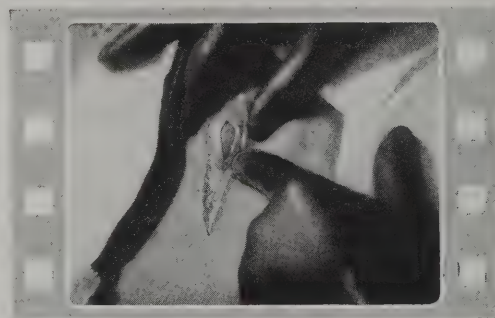
1 REEL 10 MINUTES



"Orchidopexy with Hernioplasty and Varicocelectomy"

in a man having three coincident conditions; a right undescended testicle, a hernia and a left varicocele. The anatomical relation of cord, sac, deep epigastric vessels and Poupart's ligament are clearly shown.

2 REELS 15 MINUTES



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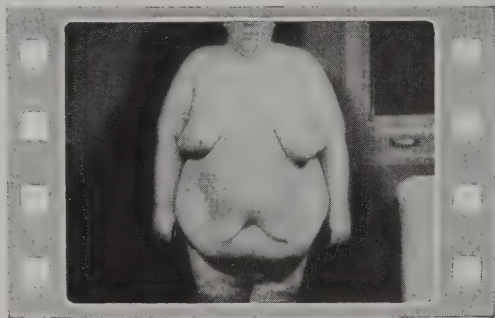
in a woman weighing 450 pounds, with lipectomy removing 35 pounds of fat through the abdominal incision one yard long, one foot wide and six inches deep.

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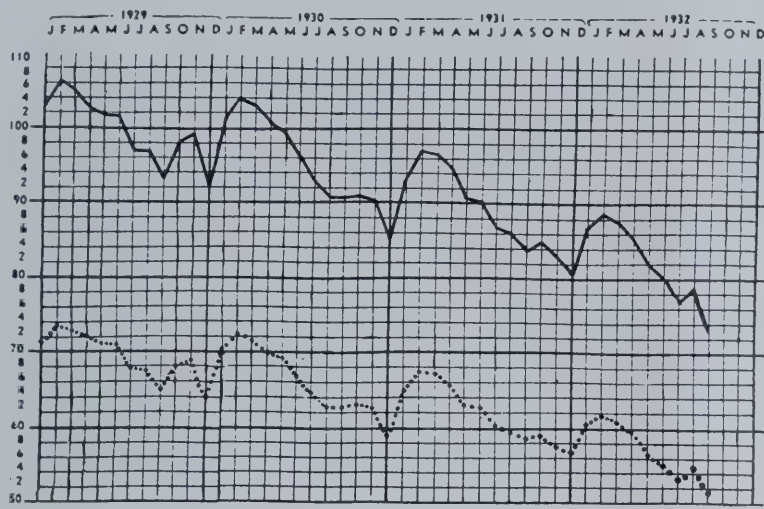


These unusual and interesting films (in the 16mm width) have been added to the D & G Film Library and are now available for bookings, without charge, to Medical Schools, Hospitals, and Professional Organizations.

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HOW'S BUSINESS?

A composite picture of the percentage of occupancy in 91 general hospitals located in 87 communities in 35 states, corrected for normal growth.



The heavy line shows the occupancy of hospitals, based on the average occupancy of 1929 as 100 per cent. The dotted line shows the actual occupancy, based on the total bed capacity of the hospitals participating in this monthly survey. During September, one reporting hospital had no patients, and reported no income or expense because of closing down as part of a building program.*

Here Are Figures From Which Occupancy Chart Was Constructed

THE following figures are the basis of the hospital occupancy chart reproduced at the top of this page. These figures were supplied by 91 general hospitals in 87 communities of 35 states, with a basic bed capacity of 16,922.

The first group of figures represents actual number of beds occupied; the second group, receipts from patients; the third, operating expenses of the hospitals for each month since the "How's Business" graphs were begun, and the fourth, occupancy, using 100 per cent as the base.

TOTAL DAILY AVERAGE PATIENT CENSUS

November, 1928	11,533
December, 1928	11,040
January, 1929	11,919
February, 1929	12,335
March, 1929	12,253
April, 1929	12,114
May, 1929	11,981
June, 1929	12,025
July, 1929	11,473
August, 1929	11,548
September, 1929	11,157
October, 1929	11,590
November, 1929	11,736
December, 1929	10,977
January, 1930	12,048
February, 1930	12,425
March, 1930	12,408
April, 1930	12,128
May, 1930	12,044
June, 1930	11,601
July, 1930	11,290
August, 1930	10,997
September, 1930	11,015
October, 1930	11,086
November, 1930	11,005
December, 1930	10,524

January, 1931	11,510
February, 1931	11,991
March, 1931	11,970
April, 1931	11,669
May, 1931	11,251
June, 1931	11,187
July, 1931	10,765
August, 1931	10,657
September, 1931	10,409
October, 1931	10,499
November, 1931	10,266
December, 1931	10,145
January, 1932	10,758
February, 1932	11,038
March, 1932	10,888
April, 1932	10,596
May, 1932	10,082
June, 1932	9,927
July, 1932	9,771
August, 1932	9,748
*September, 1932	9,125

RECEIPTS FROM PATIENTS

November, 1928	\$1,678,735.00
December, 1928	1,736,302.86
January, 1929	1,795,843.79
February, 1929	1,776,040.82
March, 1929	2,024,823.11
April, 1929	1,929,175.70
May, 1929	1,920,982.43
June, 1929	1,874,173.11
July, 1929	1,846,899.32
August, 1929	1,867,706.24
September, 1929	1,772,230.39
October, 1929	1,828,051.39
November, 1929	1,786,036.71
December, 1929	1,737,404.65
January, 1930	1,840,418.05
February, 1930	1,799,080.00
March, 1930	2,003,309.58
April, 1930	1,927,493.30
May, 1930	1,921,523.05
June, 1930	1,817,813.00
July, 1930	1,803,315.00
August, 1930	1,719,634.00
September, 1930	1,700,314.00
October, 1930	1,741,017.00
November, 1930	1,640,374.00
December, 1930	1,687,813.00
January, 1931	1,771,812.00
February, 1931	1,720,474.00
March, 1931	1,881,003.00
April, 1931	1,831,228.00

May, 1931	1,815,096.00
June, 1931	1,743,189.00
July, 1931	1,698,277.00
August, 1931	1,598,869.00
September, 1931	1,555,436.00
October, 1931	1,583,005.00
November, 1931	1,497,948.00
December, 1931	1,521,552.00
January, 1932	1,527,159.00
February, 1932	1,468,059.00
March, 1932	1,574,446.00
April, 1932	1,496,077.00
May, 1932	1,453,746.00
June, 1932	1,417,856.00
July, 1932	1,357,096.00
August, 1932	1,327,016.00
September, 1932	1,244,635.00

OPERATING EXPENDITURES

November, 1928	\$1,936,075.00
December, 1928	2,064,632.41
January, 1929	2,104,552.74
February, 1929	2,007,945.24
March, 1929	2,099,208.11
April, 1929	2,071,386.46
May, 1929	2,064,381.77
June, 1929	2,034,409.13
July, 1929	2,045,112.96
August, 1929	2,068,388.63
September, 1929	2,050,510.38
October, 1929	2,079,042.06
November, 1929	2,091,089.31
December, 1929	2,127,053.36
January, 1930	2,190,909.95
February, 1930	2,067,112.17
March, 1930	2,120,861.86
April, 1930	2,064,328.56
May, 1930	2,102,407.49
June, 1930	2,027,258.00
July, 1930	2,038,042.00
August, 1930	1,985,045.00
September, 1930	2,079,154.00
October, 1930	2,033,163.00
November, 1930	2,003,297.00
December, 1930	2,031,148.00
January, 1931	2,058,681.00
February, 1931	1,963,391.00
March, 1931	2,026,363.00
April, 1931	1,976,430.00
May, 1931	1,967,866.00
June, 1931	1,932,832.00
July, 1931	1,925,156.00
August, 1931	1,870,985.00
September, 1931	1,890,891.00
October, 1931	1,885,424.00
November, 1931	1,829,539.00
December, 1931	1,889,887.00
January, 1932	1,806,279.00
February, 1932	1,763,572.00
March, 1932	1,762,657.00
April, 1932	1,733,486.00
May, 1932	1,672,550.00
June, 1932	1,607,822.00
July, 1932	1,590,274.00
August, 1932	1,565,767.00
*September, 1932	1,508,519.00

AVERAGE OCCUPANCY ON 100 PER CENT BASIS

November, 1928	69.6
December, 1928	66.5
January, 1929	71.6
February, 1929	73.8
March, 1929	73.2
April, 1929	72.2
May, 1929	71.2
June, 1929	71.3
July, 1929	67.8
August, 1929	67.5
September, 1929	65.0
October, 1929	68.0
November, 1929	68.6
December, 1929	64.0
January, 1930	70.1
February, 1930	72.1
March, 1930	71.8
April, 1930	70.0
May, 1930	69.4
June, 1930	66.6
July, 1930	64.7
August, 1930	62.7
September, 1930	62.8
October, 1930	62.9
November, 1930	62.4
December, 1930	59.1
January, 1931	64.9
February, 1931	67.5
March, 1931	67.2
April, 1931	65.8
May, 1931	63.0
June, 1931	62.6
July, 1931	60.3
August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.5
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	55.6
July, 1932	53.6
August, 1932	54.6
*September, 1932	51.1

Have You a Plan for Replacement?

SOME superintendents try to keep before them the fact that equipment is always wearing out and that supplies are always being consumed. The consumption of supplies is more easily noticed, but some superintendents may think that just because the wheels turn around a device is giving 100 per cent return in speed, satisfaction and economical operation. It is a good idea to check over equipment and prepare to replace apparatus as it begins to wear out, before it reaches the stage where its continued use is uneconomical. The booklets and leaflets listed here will help you to learn what new models do and how much more economically and satisfactorily they operate than obsolete equipment. Ask for the leaflets by number.

Anaesthetics

No. 344. "Puritan Gas News," a publication of interest to all connected with anesthesia, gases, oxygen therapy, etc. Published by Puritan Compressed Gas Corporation. 532

No. 290. "Suggested precautions in the use of ether, ethylene and other anesthetics." Puritan Compressed Gas Corp. c30.

Cleaning Preparations, Soaps, Etc.

No. 326. "The story of soap," an intensely interesting booklet telling in story and pictures of the making of soap and soap products. Unusually well illustrated. The Procter & Gamble Co.

Cubicle Equipment

No. 337. "Privacy in the Modern Hospital" is the title of a valuable booklet on cubicle screening published by H. L. Judd Co. After outlining the problems involved in securing privacy for ward patients, the booklet works out concrete solutions for many problems. c32

Disinfectants

No. 342. A table showing the amount of Lysol disinfectant and water necessary to make solutions of various strength, together with a description of the correct solutions to use for various purposes in the hospital. Also a dilution chart for use in the laundry. Lehn & Fink, Inc. 532

Flooring

No. 334. "Resilient Floors," an interesting photograph album showing Sealex floors designed and laid in recent years. Also contains a description of the many types of Sealex floors. Congoleum-Nairn, Inc. 232

General Equipment, Furnishings and Supplies

No. 327. Booklet describing professional uniforms for nurses and others, published by Henry A. Dix & Sons Corp. b0

No. 284. "Ten Kinds of Baths." Cannon Mills, Inc. b0

No. 261. "Nurses' Apparel and Hospital Supplies," a 32-page catalog. Marvin-Neitzel Corp.

No. 341. "SnowWhite Tailored Uniforms," and "SnowWhite Tailored Uniforms for Student Nurses," two booklets describing the complete uniform line of SnowWhite Garment Manufacturing Company. Each style is well illustrated and completely described. 532

No. 323. "Standard ready dressings and supplies for hospitals," a folder showing the styles, types and sizes of ready made products. Johnson & Johnson.

No. 328. "Curity Ready Made Dressings Manual," an interesting manual showing the complete line of ready made dressings, with descriptions of uses and other informative material. Lewis Mfg. Co. L31.

No. 329. The 1932 catalog of Will Ross, Inc. Attractionally printed, well arranged catalog of the complete line of hospital equipment and supplies. L31.

tively printed, well arranged catalog of the complete line of hospital equipment and supplies. L31.

No. 333. Numerous interesting booklets and pamphlets describing the therapeutic effects, the method of manufacture, and medical history behind many "Roche" drug products. Hoffmann-La Roche, Inc. 232

No. 336. "Cotton, Gauze and Adhesive Plaster—Their Manufacture and Application in Surgery," an exceptional booklet of 96 pages. Published by Johnson & Johnson. c32

No. 339. "Kalmerid Germicidal Tablets," a pocket-size leaflet describing the composition, efficiency and uses of this new product. Davis & Geck, Inc. 432

No. 340. A complete series of pamphlets, many of which, such as "The Mystery of Sleep," "Why the Cat Unit?" and "When Chemists Turned from Gold to Drugs," are especially useful in teaching materia medica to student nurses. Available in any quantity. Hoffman-La Roche, Inc. 432

No. 314. "How to Obtain Maximum Service from Hypodermic Needles and Syringes," an interesting, pocket size manual on the selection of needles and syringes for each kind of service. Also contains practical information on how to sterilize, clean, and care for these instruments. Becton-Dickinson Company.

No. 332. Bulletin No. 260, describing the Powers thermostatic radiator valve, a self-operating regulator designed for vacuum or vapor steam heating systems. The Powers Regulator Co. 132

No. 348. Kenwood Mills, Albany, N. Y., have prepared a folder containing swatches in color of blankets and rugs, together with all necessary information concerning these hospital products. This folder is most useful for reference.

Kitchen and Food Service Equipment

No. 349. "Practical Planning for Hospital Food Service," a 62-page booklet published by the John Van Range Co., covering every detail of kitchen and food service planning and equipment. 1032.

No. 351. "Adobe Ware," a beautifully illustrated 12-page booklet describing the newest type of china for general and tray service. Onondaga Pottery Co. 1032.

No. 331. "Good Coffee," a monthly publication of interest to all quantity users of coffee. Published in newspaper style and containing many hints valuable in the preparation of coffee. Continental Coffee Co., Inc. 132

No. 300. "The Perfect Tray," by Helen E. Gilson, Onondaga Pottery Co. d0

No. 276. Modern Kitchens. A 70-page booklet. International Nickel Company. C30

No. 252. "Scientific Hospital Meal Distribution." Swartzbaugh Mfg. Co., Toledo, O.

Laundry Equipment and Supplies

No. 277. Laundry Owners' Year Book. International Nickel Company, Inc. C30

Sutures and Ligatures

No. 338. "The Bacteriological Control of D. & G. Sutures," an interesting pocket-size folder describing the various manufacturing processes of sutures. Davis & Geck, Inc. 432

Sterilizers, Stills

No. 234. "American Sterilizers and Disinfectors." Catalog. American Sterilizer Company, Erie, Pa.

No. 213. "Sterilizing Technique Series." Five booklets. Wilmot Castle Company.

Surgical Instruments and Supplies

No. 322. "Handbook on Ligatures and Sutures," 1931 edition. An interesting booklet on the history, preparation, handling and use of ligatures and sutures, completely revised. Johnson & Johnson.



Probably no incident in the whole history of nursing has more significance than that of the girl, Minna, discharged from prison, finding Friederike Fliedner and begging for refuge . . . For over a hundred years the very spirit of nursing seems to have been lost. Then Minna came to Kaiserwerth and the Fliedners.

That day marked the beginning of an experiment that has spread its beneficent influence throughout the entire world; that has hastened the swift advance of medicine and surgery; that has opened new doors of hope to thousands upon thousands of suffering children and men and women. For on that day the seed of modern, secular, trained nursing was planted.

WILL ROSS, INC., WHOLESALE HOSPITAL SUPPLIES
779-783 N. Water Street Milwaukee, Wisconsin



"We have been a little slow acknowledging the uniforms made for our Fall class of nursing students . . . We are very much pleased . . . without exception they fit well and look well . . . have taken away that look of self-consciousness which new students conspicuously wear."

Our laundry personnel is equally interested . . . feel certain that their problems are to be simplified . . ."

Respectfully yours,

Supt. of Nurses

Find New Advantages in White for Students

The above statements contained in a recent letter from a big mid-western hospital disclose two advantages of white uniforms for the nurse in training. They eliminate self-consciousness and simplify laundering problems. Why not learn more about the new plain white uniforms for student nurses which eliminate laundering of bibs, aprons, collars and cuffs?

Mail the coupon below.

SnoWhite Garment Mfg. Co.
946-948 N. 27th St. Milwaukee, Wis.

SNOWWHITE
TAILORED UNIFORMS

SnoWhite Garment Mfg. Co.,
946-948 N. 27th Street, Milwaukee, Wis.

We want to know more about the advantages of white for student nurses.

Name

Address

City..... State.....

Hospital

What Hospitals Have Learned From Present Economic Conditions—

THE "depression" has taught us—
NOT to make additions to an
already adequate hospital build-
ing unless required funds are in sight.

NOT to spread pessimism when con-
ditions are bad, but always to preach
optimism and look ahead with a smile.

NOT to wait to trim our sails, but
see to it in time that income is suffi-
cient to meet expenses. If this is not
done by administrative head, bond-
holders will see to it that someone
else does the trimming.

Believing, of course, that the next
panic such as this last one is a long
way off, and many of us may not ex-
perience another one, we should be
more conservative in our undertak-
ings. Be quite positive we have
studied the many problems ahead.
Particularly is this last so on account
of the changes expected through con-
tract or insurance medicine.—C. J.
CUMMINGS.

THE "depression" has undoubt-
edly taught hospital superintend-
ents the same lesson that it has
taught individuals. Most individuals'
standards of living have been too high
and they have thought more of luxury
than of putting away for a "rainy
day." It has taught them the lesson
that they can get along on less and
possibly enjoy life just as well. The
same applies to our institutions. We
all felt that we should have every-
thing that was possible to make things
convenient and in many instances un-
doubtedly some hospitals have tried
to outdo the other fellow and have
reached beyond their means. From
talking to various salesmen I am sure
that has been the case with the ma-
jority of hospitals.

I think the "depression" has taught
hospital executives to not order when
they do not have the money, but to
pay as they go, and the importance

of budgeting, and in that budget to
provide for a surplus. Even after the
"depression" is over I am of the opin-
ion that we will all live more eco-
nomically and will check departments
more closely, cutting out waste.

Just how we are going to overcome
the "depression" I am unable to say,
except that we must all pull together
and wherever it is possible for us to
use any supplies, order them to stimu-
late business. If we all hold back,
waiting for the other fellow, we are
not going to keep the dollar in circu-
lation.—W. W. RAWSON.

JUDGING by quotations submit-
ted to the Meadowbrook Hospital,
the "depression" teaches that now
is the opportune time for hospitals to
purchase any needed fixed or movable
equipment.—A. J. McRAE, M. D.

"WHAT do you think is the
most important lesson the
depression has taught the
hospital field?"

Among other things which hos-
pitals should have learned is in times
of expansion to lay by reserves for
times of depression. To keep expendi-
tures within the income received for
care of patients and other resources
available for operating expenses.

Another thing which hospitals
should have learned is to differen-
tiate between essentials and non-essen-

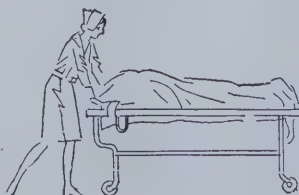
tials. By non-essentials I mean refine-
ments in service which in years of
plenty are considered necessary, but
in years of stress may be considered
luxuries.

Hospitals have learned practical
economies, many of which were dis-
cussed in round table conferences at
the meetings of our national hospital
associations in Detroit last September.

How may the problems involved
be met? By careful and consistent
planning of work, not expanding sim-
ply because some other hospital has
done so, exchange of facilities with
neighboring hospitals and improving
public relations through suitable na-
tional, state and local publicity.—
C. S. PITCHER.

AS to the most important lesson
which the "depression" has
taught the hospital field, I de-
sire to briefly express my views but
with very little comment or argument:

I am quite sure the "depression"
will stimulate hospital executives to
study more carefully the financial
problem of the hospital in its various
elements, or to be more explicit, es-
tablish and maintain better cost ac-
counting systems. I believe most hos-
pital executives today are better in-
formed on unit costs than they were
a few years ago. I am sure that the
business administration of hospitals
will receive more individual and or-
ganized group consideration in the
future. This will lead to better sys-
tems of accounting standardized to
such a degree as will set forth more
clearly comparative costs. I also be-
lieve the "depression" will tend to
give greater study to the entire eco-
nomic problem of hospitals, with par-
ticular attention to budgeting, as well
as the relation of expenditure to serv-
ices rendered.—MALCOLM T. MAC-
EACHERN, M. D., C. M.



What's This?—

"A Year's publicity program,
designed to encourage donations
and more generous co-operation from
the public, for \$110 or less?

"Yes, let's send for details about
this today."



HOSPITAL NEWS
537 South Dearborn Street
CHICAGO - - ILLINOIS

HOSPITAL NEWS,
537 South Dearborn Street, Chicago.

Please tell me about the year's publicity service for hospitals
that will cost \$110 or less.

We understand that there is no obligation involved in this
request.

My Name

Hospital

City, State

A Page of Letters to the Editor

WANTS AN ANNUAL REPORT

Editor HOSPITAL MANAGEMENT: I am afraid I have omitted to notify you of the change in my address. Would you please in future send the magazine monthly to the above hospital?

I feel I should say that I am particularly interested in your publication, and it is most useful in keeping one posted with hospital matters on the other side of the Atlantic.

Could you send me a hospital annual report?

GEORGE W. COOLING,
Secretary, Metropolitan Hospital,
Kingsland Road, E. 8, London,
England.

THE NEWARK PLAN

Editor HOSPITAL MANAGEMENT: You will be interested to learn that the Executive Board of our Council has adopted a group hospital insurance plan and we expect to initiate the movement on or before December 1. We are now awaiting the final approval of our member hospitals, most of whom have already agreed to join.

It is our purpose to form a subsidiary organization of the Council which will be officered and directed by representatives of the hospitals included in the plan. This organization will effect arrangements with a group of local business and insurance men to conduct the sales and administration effort involved in the operation of the plan.

This sales organization is being formed at our request and will provide the facilities and proper actuarial analysis and sales effort in harmony with the ideas and principles of our member hospitals. We feel that this arrangement will provide the best possible advantages.

The annual membership fee will be \$10 and includes a guarantee of all essential hospital service including X-rays, up to 21 days per year and 33 1/3 per cent discount beyond the first 21 days' hospitalization. Participating hospitals will be paid on the basis of a flat rate of \$6 per patient day. It is anticipated that this arrangement will yield a reserve which will be retained to meet any possible contingencies which might arise as the result of abnormal demands. The bills for service at this rate will be forwarded by the hospital to the Council office and remittances will go direct from the Council office to the hospital. The Council office will provide this service for the subsidiary organization which includes the participating hospitals, thus avoiding additional overhead.

As soon as all preparations have been completed, I will be very glad to forward you a copy of the completed plan and procedure involved.

FRANK VAN DYK,
Executive Secretary, Hospital Council
of Essex County, Newark, N. J.

"INSURANCE IS COMING"

Editor, HOSPITAL MANAGEMENT: Kindly accept my thanks for the additional information you sent relative to the subject

"HOSPITAL MANAGEMENT" again expresses its appreciation of the interest which has been shown in these pages of Letters to the Editor. Again we thank those who have so kindly volunteered to answer the questions which have been asked and thus to supplement information which has been sent directly to the writer.

These Letters to the Editor will serve their purpose, which is to provide comments and information of interest and to suggest problems with which some hospitals are engaged, to an even greater degree, if readers will correspond directly with those whose inquiries appear. We would like to have copies of letters answering specific inquiries, and we also welcome comments, suggestions, criticisms, etc., expressed in letter form, from any reader.

of hospitalization insurance. There is no doubt but that the subject of hospitalization insurance is a live topic and to my mind is only a matter of a relatively short time before the majority of hospitals will participate in such a plan.

I realize that but a few hospitals have ventured into any sort of an insurance scheme and it is interesting to note through published reports the varied experiences some of these hospitals have had. It would seem to me that the very success of hospitalization insurance depends upon the inclusion of family groups, thereby making it possible for all individuals in a given community to participate in the insurance plan on the same basis as employees of business firms, who, in almost all instances, are the only groups participating at the present time. Of course, I realize that only a scattered few hospitals are pioneering in hospitalization insurance, and the results some of these hospitals have had, even though they have confined their activities to isolated groups, would seem to indicate that hospitalization insurance is bound to succeed.

There is one point on which I am not clear. The point is this: "Why have not insurance companies, having unlimited resources behind them, having nationwide representation and having unlimited experience in all forms of insurance, come forward long before this with some plan of hospitalization insurance which would be acceptable to hospitals?" I can readily understand that hospital insurance to be most successful must be planned and worked in such a way that the ward class will participate. In order to procure their participation, I can see where it is necessary to make an attractive offer which means a long period of hospitalization at a low premium rate.

It is obvious, therefore, that to attain the best results one might argue that if the insurance companies actively promoted hospitalization insurance, they would naturally have to do it on a profitable basis, whereas if hospitalization insurance is promoted by the hospitals themselves, individually or collectively, the profits could be shared by the hospitals and the policyholders.

JOHN N. HATFIELD,

Superintendent, Pennsylvania Hospital,
Philadelphia.

LET'S HAVE SOME FIGURES

Editor, HOSPITAL MANAGEMENT: From time to time, I have seen statements regarding laundry costs in HOSPITAL MANAGEMENT. I know all the hospital executives are interested in laundry costs as well as the cost sheets of any other department. I believe we would also be interested in the laundry costs of other institutions if they would tabulate it, so we could have some basis for comparison, but to date I have never seen any citation of costs in your journal that are in any way informative. Two such meager statements are found in the October issue which give no one any basis for comparison, because they simply state the number of pieces of laundry done and their expenses are tallied, in laundry supplies and payroll.

The executive of one of the aforesaid hospitals states that a local laundry bid three times his present cost on the same work. Now, in these days of keen competition in laundry work, as in all other lines, it would seem that such a variation in estimates could not occur if both parties were figuring on the same basis on actual costs. If I figured my laundry cost on just the cost of supplies and actual payroll, I would have a delightful per piece cost, but it is no use trying to kid ourselves by any such unbusiness-like manner of bookkeeping, for if we wish to arrive at anywhere near an approximate cost, we must take at least the following items of expense into consideration: salaries, including vacations, board and room if the employees live in the institution, laundry supplies, including padding and covering for mangles and presses, depreciation on laundry equipment, electric power, insurance, maintenance of the building, painting, repairs, heat and light, and total cost of water, both hot and cold.

After we have figured our cost with these items included, possibly we will find ourselves figuring more nearly from the angle of the local laundry man. Even then we haven't charged up the interest of the investment or on laundry equipment and real estate. On this basis I doubt very much if we can cut our costs to 300 per cent below the commercial laundry, but we should at least attempt to save the percentage of profit which the commercial laundry anticipates.

I am sure all hospital executives at one time or another would have welcomed some authoritative information by which they could have compared their laundry costs with other institutions of similar type and size.

If you have any such information in

your files, I believe it would find warm acceptance in your journal. I, personally, would appreciate any information you may have to assist me in arriving at the cost of hot water.

Attempting to get the cost of hot water is rather difficult in a sanatorium where all equipment is used in common in producing steam and hot water for general hospital purposes. It is an easy matter to arrive at the cost of coal from a b.t.u. standpoint, but when part of the time of your fireman, engineer, service men, and depreciation, repairs, boiler compounds and lubricating oil is taken into consideration, it becomes almost impossible to know what part of these charges should be taken into consideration in figuring cost of hot water for laundry expenses as in our case where all of the hot water and steam come from the same boilers and tanks for laundry and general sanatorium purposes. So anything you may be able to do for me in this line will be greatly appreciated.

WILLARD BOYDEN HOWES, M. D.,
Superintendent, Detroit Tuberculosis
Sanatorium, Detroit, Mich.

WHO WILL HELP?

Editor, HOSPITAL MANAGEMENT: I am making a study of the early history of hospitals; leaders in hospital work; place of research in hospital organization; relation of hospital organization to economic world; and hospital organization trends.

Could you furnish me with any material such as surveys, studies, etc., beyond the material I can get from reading your magazine.

I shall appreciate any courtesy you may be able to extend to me.

MISS M. S. WHARTON, R. N.,
Superintendent of Nurses, Chelsea
Memorial Hospital, Chelsea, Mass.

HOSPITAL TEMPERATURES

Editor, HOSPITAL MANAGEMENT: We are interested in finding out what hospital superintendents in general consider the proper temperature for hospitals, rooms, wards, and nurses' homes. We have a 200-bed teaching hospital, which means that a great many students and doctors are continually working with patients. This might require a little higher temper-

Readers Help Readers Through These Letters to the Editor

THE popularity of these pages of Letters to the Editor has been apparent since this feature was begun, and each month gives proof of the fact that the letters are not only read and commented on, but that specific requests for information or suggestion also are answered, in most cases directly to the reader whose letter contains the request.

Every reader is invited to comment on articles, editorials or problems discussed in any issue of HOSPITAL MANAGEMENT, and also is invited to suggest topics for discussion. Invariably it is learned

that the problem that interests or puzzles one reader also troubles or intrigues many others, and for this reason the discussion of any suggested topic is gladly undertaken.

Only a very few of the letters received by the Editor appear on these pages, an effort being made to select those which give some point of view to a particular question, and also those letters requesting information that is most valuable when it comes from a number of hospitals, rather than in the form of an abstract opinion.

ature than that in private hospitals. It also is appreciated that temperatures depend directly on relative humidity.

R. B. SAXON,
Operating Superintendent, University
of Nebraska College of Medicine,
Omaha, Neb.

STUDYING "HOW'S BUSINESS?"

Editor, HOSPITAL MANAGEMENT: As a matter of interest to myself, and in order to give our Board some information as to comparison of our conditions with a representative group of hospitals, I have had the data which you have been running for several years under the heading, "How's Business?" worked down to an average condition of each hospital represented for the first six months of the year 1932 as compared with 1930, in comparison with our own condition in 1930.

In some respects, there is a strikingly close parallel; in others an almost unbelievable difference. This is particularly true as far as the difference in operating deficit is concerned.

The average condition of each hospital

of this composite group has had an operating deficit of \$1,600 more during the first six months this year than during the same period in 1930. Our own figures show that our operating deficit has been 88 per cent eliminated, using the figures representing our actual cash receipts rather than our earnings charged, or a reduction of approximately \$103,000.

I am enclosing a copy of this compilation, which is at least interesting. I do not believe that if you should be inclined to make use of these figures, that I should care to have the name of this hospital mentioned.

I assume that the 91 hospitals furnishing you with information are going hospitals in practically every instance, rather than new hospitals, with only a portion of their plant in use, as is true in our case.

Of the beds actually in use (166) over the period of the first six months of this year, our percentage of occupancy has been 50.9 per cent, so you see the Board of this hospital built for the future, apparently for many more years than they realized, when this plant of 275 beds (250 beds plus 25 bassinets) was erected.

READER.

AVERAGE FOR FIRST SIX MONTHS OF 1930-31-32, OF 91 HOSPITALS IN 35 STATES

	1930	1931	1932	1931 % of 1930	1932 % of 1930	Increase or decrease 1931 over 1930	Increase or decrease 1932 over 1930
Total beds	186	186	186	..	..
Daily average patients.....	130	121	110	93	85	-9 or 7%	-20 or 15%
Per cent of occupancy.....	70	65	59	93	85	-5%	-11%
Receipts from patients.....	\$124,281.73	\$118,668.15	\$98,212.56	95	79	-5%	-21%
Operating expenditures % inc. and dec...	138,163.49	131,050.14	113,696.33	95	82	-7113.35 or 5%	-24467.16 or 18%
Cash deficit % inc. and dec.....	13,881.76	12,381.99	15,483.66	89	110	-1499.77 or 11%	1601.90 or 10%
Per capita cost.....	5.71	5.68	5.39	99	94	-.03 or 1%	-.32 or 6%

FIGURES FOR FIRST SIX MONTHS OF 1930-31-32 OF ONE HOSPITAL

	1930	1931	1932	1931 % of 1930	1932 % of 1930	Increase or decrease 1931 over 1930	Increase or decrease 1932 over 1930
Total beds	275	275	275	..	..
Daily average patients.....	125	123	98	98	78	-2 or 2%	-27 or 22%
Per cent of occupancy.....	45.5	44.3	35.6	98	78	-2%	-10%
Receipts from patients.....	\$119,317.12	\$110,840.03	\$94,666.96	93	79	-7%	-21%
Operating expenditures % inc. and dec...	235,732.29	166,051.42	108,409.44	70	46	-69680.87 or 30%	-127322.85 or 54%
Cash deficit % inc. and dec.....	116,415.17	55,211.39	13,742.48	47	12	-61203.78 or 53%	-102672.69 or 88%
Per capita cost.....	10.39	7.45	6.11	72	59	-2.94 or 28%	-4.28 or 41%

The figures shown above are discussed in the last letter on this page.

SO MUCH THINNER...



Their tactile touch is second only to that of the bare fingers; they are virtually tear-proof, stubbornly resistant to sterilization, shelf wear

SURGEONS who have adopted the Miller Anode glove say their hands are surprisingly more comfortable. They can move their fingers more freely.

Their gloved finger tips are more sensitive. . . . Tactile touch, they are delighted

to find, closely approximates bare-finger sensitivity.

Nurses report that Miller Anode gloves stand up under sterilization and last about twice as long as ordinary surgeons' gloves. In operating rooms where surgeons' gloves used to be discarded after three wearings, Anode gloves are now used six times and more, with absolute safety.

Samples for your own tests will be furnished free by your supply house. You can identify the genuine Miller Anode glove by the blue band at the wrist.



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Fountain Syringes • Anode Penrose Drains • Catheters • Colon, Rectal and Stomach Tubes • Rubber Tubing

HOSPITAL MANAGEMENT

A Practical Journal of Administration



Importance of Good Executive Recognized by A. C. S.

Annual Report on Hospital Standardization for
First Time Indicates That Approval Has Been
Delayed Because of Immature Superintendents

By MATTHEW O. FOLEY

FOR the first time in its history the American College of Surgeons in its annual report on the Hospital Standardization movements this year indicates that it has taken cognizance of the importance of a qualified superintendent. A part of this report reads:

"In a few instances it has been necessary to withhold final decision on rating the hospital until the immature superintendent has proved his or her ability to administer such an institution. It is difficult to have the Hospital Standardization requirements carried out in a proper manner when the superintendent is not familiar with hospital administration."

HOSPITAL MANAGEMENT has frequently stressed the importance of giving recognition to the fact that an experienced superintendent should have proper support and that some acceptable means of identifying such a superintendent and of setting him or her apart from inexperienced candidates for positions should be adopted.

Every progressive superintendent and everyone interested in the promotion of better hospital service through the better preparation of superintendents will hail this recognition of experience on the part of the American College of Surgeons. Each superintendent should bring this matter to the attention of trustees and others in order that the weight of the influence of the College which is so strong among trustees and staff members

Here are comments on a very important matter to hospital superintendents and to those who plan to make the administration of hospitals their life work. The American College of Surgeons for the first time in its history has gone on record in its annual report on Hospital Standardization as to its recognition of the value of an experienced administrator in carrying out the standardization program in a given hospital. "Hospital Management" welcomes comments on this article and on the general subject involved.

may be brought behind the general movement to gain more prestige for the vocation of hospital administration.

This recognition of the important part that an experienced superintendent can and does play in the success of the Hospital Standardization program will be especially welcomed by the many men and women, many of them non-medical in training, who by their courageous and insistent efforts have helped to win hospital boards

and medical men to the Hospital Standardization movement. As HOSPITAL MANAGEMENT has occasionally emphasized, a very great part of the success of the movement inaugurated by the American College of Surgeons has been due to the heroic efforts of conscientious superintendents, some of whom at the risk of losing their positions have courageously held out and have fought for the principles of Hospital Standardization and have eventually won trustees and physicians to their point of view and thus added to the length of the annual approved list.

It is to be hoped that the effort thus publicly announced will be continued by the College and that in the future there will be even closer investigation of the qualifications and ability of the superintendent. Special investigation ought to be made of incidents where competent and experienced men and women have been displaced and supplanted by people entirely ignorant of hospital service.

HOSPITAL MANAGEMENT warmly congratulates the College and those superintendents who have the interests of their calling so much at heart in the recognition indicated in the following excerpt from the 1932 report on Hospital Standardization:

"The administration of hospitals of the United States and Canada continues on an upgrade of efficiency, but many institutions may be threatened by the entry into this work of untrained and inexperienced admin-

istrators. Inasmuch as hospital administration must be regarded as a science and an art, it is impossible for the raw recruit to plunge into this work without having served a thorough apprenticeship with a master superintendent.

"In a few instances it has been necessary to withhold final decision on rating the hospital until the immature superintendent has proved his or her ability to administer such an institution. It is difficult to have the Hospital Standardization requirements carried out in a proper manner when the superintendent is not familiar with hospital administration. That there are so many changes in hospital superintendents is indeed regrettable. Not infrequently exceedingly high grade executives have been deposed because of the unreasonable attitude of a member or members of the governing body or board of trustees, through one of them being desirous of assuming this position, or owing to the intriguing of one or more members of the medical staff.

"Unfortunately, in some of the institutions under survey, particularly tax-supported hospitals, politics have played too prominent a part, thereby causing good administration and efficient service to the patient to be sacrificed through this deplorable condition.

"It would seem apparent from a careful survey of the hospital field that there must be better stabilization of hospital administration. In the absence of organized courses in hospital administration it will be expedient for some time yet for hospital executives to gain their experience entirely through apprenticeship as mentioned above."

HOUSEKEEPERS CONFER

Mrs. Adele B. Frey, Ohio State president, National Executive Housekeepers' Association, and executive housekeeper, Hollenden Hotel, Cleveland, was in Cincinnati recently for a conference with President Mary E. Hayes of the Cincinnati chapter. Miss Hayes called her board of directors together at Netherland Plaza to meet President Frey and discuss plans for the semi-annual state meeting to be held in Cincinnati early in 1933. The board of directors are Mrs. Grace A. Berger, Hotel Gibson; Mary Curran, Hotel Sinton-St. Nicholas; Mrs. Baber, Longview Hospital; Mrs. Portia Hufford, Parkview Hotel; Mrs. W. D. Miller, Cincinnati Country Club; Mrs. Ella Faulder, Hamilton County Sanatorium.

PENNSYLVANIA MEETING

Officers of the Hospital Association of Pennsylvania have selected March 21, 22 and 23 as the time and the Bellevue Stratford Hotel, Philadelphia, as the place of their 1933 convention.

Fourteen Conventions in a Row

HOW many superintendent members of the American Hospital Association can equal the record of Dr. Walter E. List, superintendent, Jewish Hospital, Cincinnati, who has attended fourteen conventions in a row?

Dr. List has registered present at the following meetings:

Cincinnati, 1919
Montreal, 1920
West Baden, 1921
Atlantic City, 1922
Milwaukee, 1923
Buffalo, 1924
Louisville, 1925
Atlantic City, 1926
Minneapolis, 1927
San Francisco, 1928
Atlantic City, 1929
New Orleans, 1930
Toronto, 1931
Detroit, 1932

Dr. List began to attend conventions before he joined the A. H. A., not affiliating with the association, according to its records, until 1920, when he became superintendent of the Minneapolis General Hospital. Prior to that he was assistant to Dr. A. C. Bachmeyer, Cincinnati General Hospital. Dr. List has written only two hospital names after his own on his registration card at these 14 conventions



—the Minneapolis General, of which he was in charge until 1930, and the Jewish Hospital.

Dr. List is regarded by his many friends as a capable and progressive administrator and a man who is deeply interested in the advancement of hospital administration, a subject to which he has given much thought. Hospital literature is among his hobbies, and he has one of the most complete collections of A. H. A. transactions and publications in the field.

Urges Support for Hospitals

A warning to the public against forcing the voluntary charitable hospitals of the United States—which served more than 5,000,000 patients last year—to lower their standards was issued recently by Dr. William F. Snow, president of the National Health Council. "The finances of the charitable hospitals have suffered greatly," he said, "and notwithstanding the urgency of contributions to emergency relief agencies, the public must support the hospitals liberally if it expects the hospitals to continue to give the best that medical science can offer.

"According to statistics prepared by the American Medical Association," said Dr. Snow, "110 hospitals closed their doors in 1931 and other hospitals are considering such a move because of the financial stringency. There are more than 4,500 of these

voluntary charitable hospitals in the United States, many of which have found it necessary to close a large number of their wards and private rooms.

"The American Hospital Association has pointed out that in the voluntary charitable hospitals the spread between income and expense has been greatly increased in the last three years. On the average they are now giving more than 30 per cent of their services to patients who cannot pay the cost of their care, while their earnings have fallen off 15 to 20 per cent. For years past they have had to look to the American public for some \$100,000,000 in contributions for the support of this free work."

Dr. Kendall Emerson, director of the National Tuberculosis Association, called attention as a preventive measure to the necessity of maintaining the health of the public through hospitals, clinics, and the public health nursing service.

"Hospital Insurance Is Difference Between Solvency, Insolvency"

Here Is a Statement from Dallas Methodist Hospital
Which Has 4,889 Policy-Holders in Its Plan; Institution
Has Had 22 Months' Experience With Its Program

By J. H. GROSECLOSE

Superintendent, Dallas Methodist Hospital, Dallas, Tex.

DURING recent months there has been a good deal written about group hospitalization, and a number of speeches have been made on the subject. In the main this publicity has been given by persons who had not had practical experience with the plan as we are using at this hospital. HOSPITAL MANAGEMENT asked the writer more than a year ago to prepare an article for the magazine. My answer to this was that it was too early to give out information about it as it was still purely an experiment. I think now the time has come when something might be said that is worthy of consideration. Please bear in mind that I am talking from an experience of twenty-two months' actual working of the plan.

In the first place, I would like to say that it is my judgment that the plan should be inaugurated through a sales agency. We were very fortunate in having the National Hospitalization System of this city to undertake the sales campaign for this hospital. We entered into a contract with them to sell for us during the first year two thousand certificates, with a maximum of ten thousand during five years. We have at this time an active membership with all dues paid, many of them reaching back to December 1, 1931, of 4,889. There have been a great many cancellations owing to the financial situation, particularly in the industries of our city. Our net cash income for the month of September was \$2,110. In a hospital with a budget of practically \$11,000 and with a payroll of \$3,600, this amount of money represents the difference between solvency and insolvency.

It is too much to expect at this early stage of the enterprise that the money received from this source would pay for the hospital service rendered at the regular price charged to the general public; but if figured on a contract basis, it is by far the best contract that we have been able

Here's another brass tacks talk on hospital insurance by a man who has had an insurance plan in effect for 22 months. Last month we presented a detailed description of the plan now in effect at Memorial Hospital, Houston, Tex., with a copy of the contract between the hospital and the subscriber. In the next issue we will have the plan in use in Sacramento, Cal., detailed, while facts about other plans are being worked up by others for publication later.

to get with anybody. My auditor, who has just completed an audit of the hospital as of August 31, was very skeptical about the insurance plan. He makes the following comment in this audit:

"From the above it can be seen that the income per patient days without the benefit of the National Hospitalization contract is \$7.12, while the expense per patient day amounted to \$7.88, showing a loss without the National Hospitalization contract of 76 cents per patient day. The reason for this is that exclusive of dietary expense, linen expense and medicines, the cost of maintaining the patients' rooms, whether occupied or not, is the same; and by having the benefit of the hospitalization patients, the total expenses were reduced by the amount of cash received on the policies of these National Hospitalization contracts, thus reducing the cost per patient day in proportion so that by having the benefit of the National Hospital contract, instead of operating at a per patient day loss of 76 cents, you op-

erated at a per patient day profit of 21 cents, thus being profited in the amount per patient day of 97 cents."

It is my conviction that in the centers where there are a great many employed people, the plan as outlined by the National Hospitalization System has the following advantages:

1. It makes the services of the hospital available to all employed people, regardless of their financial condition, and relieves them of the necessity of becoming charity patients.

2. It enables the hospital to overcome the problem of empty beds, and while rendering a real service to the middle classes, it is being done on a profitable basis to the hospital.

3. By employing a sales agency, the hospital is able to get this business without sales cost and maintenance cost to the plan, and at the same time keep the price within the reach of all employed people.

Since the hospital's connection with the launching of this movement has been given such a wide publicity through the Rosenwald Foundation, a government bulletin, and hospital magazines over the country, inquiries have come from every part of the United States and Canada for information. It is not possible for me to give this information unless I employed a special secretary. I have arranged for the National Hospitalization System, 615 Praetorian Building, Dallas, Texas, to answer all inquiries, and if information is desired, kindly address them rather than the Dallas Methodist Hospital.

MR. BRIMMER DEAD

Many friends of Carl A. Brimmer, formerly superintendent of Mansfield, O., General Hospital, and Jameson Memorial Hospital, New Castle, Pa., died at the home of his parents in Battle Creek, Mich., October 15 after a lingering illness. Mr. Brimmer was active in the Ohio Hospital Association during his residence in that state and was president of the association just prior to his removal to New Castle.

Widespread Interest Shown in Hospital Insurance

INTEREST in the subject of hospital insurance received renewed impetus at the hospital conference of the American College of Surgeons last month. The article in October HOSPITAL MANAGEMENT by Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., was widely commented on then, and requests for copies of this issue indicated the interest in the Houston plan in other quarters.

New York, Chicago and Philadelphia are among some of the larger cities in which hospitals, individually or in groups, are giving serious thought to the development of a plan whereby a definite amount of hospital service may be made available to the person of moderate means for a specific annual fee. In some instances, as in Newark, the plan is considered practically ready to put into effect, and in other places the local association has named special committees to gather all information to present a plan that will help hospitals to solve this troublesome problem of trying to supply service to those unable to pay and who have no agency or individual to aid them.

Progressive hospital superintendents and others in different centers have advised HOSPITAL MANAGEMENT of the development of their plans, but have asked that nothing be said to the field at this time, or until some little experience with the program is available.

Hospital care for a period of three weeks may be made available to members of gainfully employed groups at an expense to the individual of about what he pays for his daily paper is considered by the Hospital Conference of the City of New York. After listening to a description by Frank Van Dyk, executive secretary of the Hospital Council of Essex County, of the plan which has been recommended to the hospitals of Essex County, the New York Conference appointed a committee to study in cooperation with a committee of the United Hospital Fund the merits of group hospitalization.

The plan as recommended to its member hospitals by the Essex County Council provides for group participation only of persons of both sexes between the ages of 15 and 65 and gainfully employed. Each individual of the group would contribute 85 cents a month or \$10 a year

"Hospital Management" will be glad to tell the field of insurance plans being developed by hospitals or put into actual operation by them. Pioneers in this movement can be of great assistance to their co-workers in other cities by describing for them some of the features of different plans and commenting on factors that are important when a plan is started.

through a payroll deduction or as might be otherwise arranged. The employer would collect the payments and turn them over to a common hospital fund, from which the hospitals furnishing the service would be reimbursed. On its part each participating hospital would furnish these individuals, whenever necessary, with a maximum of 21 days of care in semi-private accommodations. The care would include board, nursing, use of operating room, laboratory tests, X-rays, anesthetics, drugs, dressings, attention of hospital medical staff and other hospital facilities, exclusive of physicians' or surgeons' fees. The only hospital cases not benefiting under the plan are chronic mental, tuberculosis and contagious diseases. This service does not apply to patients eligible to treatment under the Workmen's Compensation



Act, but does apply to accidents and other illness.

In Philadelphia one plan announced includes 30 days' care in a private room or ward, according to the annual fee paid, nursing, ambulance, medicines, dressings, laboratory, X-ray, electrocardiograph, basal metabolism, and blood transfusions, as ordered by the physician, "and other services." Contagious patients and patients coming under the workmen's compensation law are not eligible, but accident victims may receive service with the plan.

The general feeling among those who have given some thought to the program is that a plan of hospital insurance, that is, a plan whereby a group or groups of individuals in the same community may obtain needed hospital service, under definite conditions, upon the payment of a nominal annual fee, is feasible and that it is a plan that deserves development by the field generally. In some centers hospitals are launching such a program independently, mapping out a program by themselves when other hospitals incline to hold back. In other cities the group idea, similar to that in San Antonio, Houston, Sacramento, and other places is favored, as the hospitals feel that the more hospitals there are in a plan the more physicians there will be who will endorse it.

WANTS LIEN LAW

The Missouri Hospital Association held a special meeting during the hospital conference of the American College of Surgeons in St. Louis to discuss details of a lien law. Dr. B. W. Caldwell, executive secretary, American Hospital Association; the Rev. M. F. Griffin, trustee, A. H. A., and Dr. J. Rollin French, of the workmen's compensation committee of the A. H. A., were among guests present, there being about 40 hospital executives at the luncheon, over which E. E. King, president, Missouri Hospital Association, presided. The state legislative committee, for whose benefit the comments were elicited, is composed of: L. Eleanor Keely, chairman, superintendent, Boone County Hospital, Columbia; John R. Smiley, superintendent, St. Luke's Hospital, Kansas City; E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis; Walter Grolton, superintendent, Missouri Pacific Hospital, St. Louis; Dr. R. Emmet Kane, chairman of executive committee of staff, De Paul Hospital, St. Louis.

NO CHEST NOW

A recent meeting of leading social agencies of New York City came to the conclusion that a movement for a community chest for New York City "is neither desirable nor practical at this time." It is explained that this decision is not offered as covering conditions in normal times, but merely a statement of the opinion of representatives of these organizations concerning the value of a community chest in 1932.

Planning a Store Room to Save Time, Steps and Supplies

Here Is How One Superintendent Would Locate and Equip This Highly Important Department of the Hospital

By MURRAY C. GODDARD

Superintendent, The Polyclinic Hospital, Cleveland, O.

PLANNING the location, arrangement and equipment of the storeroom to obtain effective and economical service is of considerable importance to a hospital whatever its size and merits, the most serious consideration of the architect and consultant.

Approximately half of all hospital expenditures pass into and out of the storeroom in the form of supplies and it would seem obvious that such a department planned, equipped and staffed for maximum efficiency may add much to the effective operation of any hospital, not only in a financial way, but also in improving some portions of the service to patients, which is no small part of the aim of all good hospitals.

There are few hospital administrators who will not admit the desirability of grouping all supplies at one point, nor the fact that misuse and losses will be kept at a minimum if supplies are inaccessible except to a very few persons and then dispensed in the exact quantities needed for immediate use.

Not many hospitals are either planned or equipped to attain maximum efficiency in disbursing supplies. They must attempt to approach perfection by close supervision and a system of requisitions and inventories checked and counterchecked. A very common system involves a storage of commonly used supplies on each division in the hospital, which is kept up to standard by weekly requisitions on the main storeroom. Under this plan these supplies must be kept readily available to considerable numbers of employes and others, and if they were absolutely protected from misuse or pilfering, there would be necessary something of the guard system in evidence at a Federal Reserve Bank.

Too often the hospital storeroom is allotted space which no other department wants and not infrequently it is necessary to store supplies in dif-

ferent parts of the building and sometimes available to all who need them.

It is not unusual for the storekeeping duties in the small hospital to be divided among a number of employes; thus, the janitor would care for some, the maintenance man another part, the laundry man handle the linen supplies, and the laboratory technician dispense the drugs, and so on. And as to stockkeeping, it's just what the harassed and overbusy superintendent is able to keep in her memory when a salesman comes for an order. The wonder of it is that so many of these small hospitals really approach the efficiency of the larger institutions both in service and cost.

It is true that many small hospitals operate their storerooms with just as adequate a system as any large hospital, and to such this article can be of small benefit, but it seeks to suggest a more scientific plan for the small hospital not yet built. It is believed that such an institution, par-

ticularly if contained within one building, may be arranged more nearly to attain maximum efficiency in the storeroom than most large institutions with proportionately greater expense in this department.

In planning for efficiency in the small hospital storeroom we must consider how the axioms stated in third paragraph may be most effectively put into operation. The first principle, that of storing all supplies in one place, may always be planned for in the new hospital if the necessity is stressed to the architect.

All factors affecting the location of this one supply room must be given careful consideration in order to permit the most efficient plan of operation to be carried out. First in order of importance as affecting cost of handling supplies is the proposed system of transportation. It must be decided whether the maximum use will be made of mechanical energy, whose first cost is greater, or of human energy, whose operating cost is



How the author would store surgical and medical sundries and drugs in a small hospital storeroom. See next page for floor plan indicating location of this section of room.



"Dietary supplies should be kept in a separate room at lower than ordinary temperature, with bulk and barreled supplies farthest from the point of exit." Floor plan below shows where this section of storeroom would be located.

larger. If the decision is for the mechanical system, it should be known that vertical transportation is less costly than horizontal transportation, and that for the usual small hospital a combination of mechanical transportation vertically by elevator and dumb waiter together with the horizontal transportation by human energy in the form of the nurse from the dumb waiter to the patient will provide the most effective system, giving due consideration to first cost as well as operating cost.

If such a combination plan of transporting supplies be used, it is obvious that the mechanical part of the system must deliver the supplies at a central point on the floor where they will be used in order to equalize the human travel on the division and to afford proper supervision at that end.

Another factor that must be considered is the point of receipt of supplies in the storeroom. As goods are usually delivered by others, this has little effect on costs, but, as every doorway into a storeroom is a possible source of loss, the receiving door should be located where it may be easily supervised by the storekeeper from the place where he will be kept most busy, and if possible this door should also be visible to some other person, preferably someone in the main office where the bookkeeping is done.

As many of the bulky stores go to the kitchen, the two departments should be near each other in order to permit perishable and daily supplies to be easily checked directly into the kitchen.

The second axiom, that of keeping stores inaccessible to most employees, may be carried out in the small hospital with but one storekeeper by having this person on duty during the day when the demand for supplies is greatest and giving authority to few others. During the night this might be the night supervisor.

The third point, that of dispensing supplies in small quantities for immediate consumption, can well be carried out in such a central storeroom, served by a dumb waiter to each floor, and where the clerk is usually on duty at all times during the busy day.

Ordinarily the storeroom duties in the hospital of less than 100 beds are not such that they occupy the entire time of one person so that it is common to assign many other duties to him, but under the plan here proposed our storeroom becomes also a central dressing room and the storekeeper should be given much of the work of preparing and sterilizing surgical supplies, setting up dressing trays, preparing stock solutions, etc.

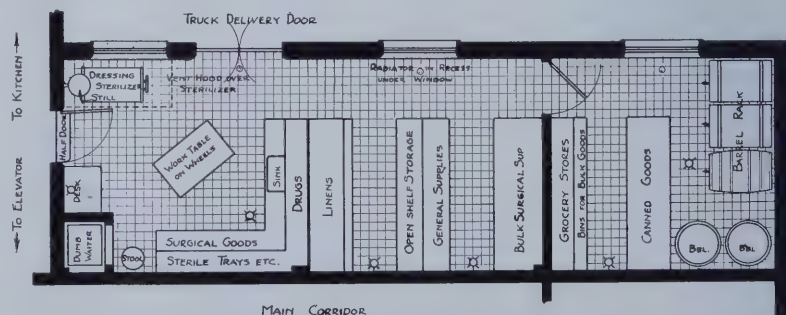
Such a position will require the services of more than an ordinary individual, and if the employee has had pharmacy experience, an adequate salary can well be afforded.

The layout and equipment of the storeroom should be based on the premise that as far as is reasonably possible, items will be stored as to departmental use and in such order as to accessibility; that those most in demand will be nearest the point of departure from the room. This system is the basis of all so-called industrial efficiency plans which have accomplished much in increasing production and lowering costs in factories.

A survey of the hour by hour needs in any hospital will indicate that surgical, medical and drug supplies are in most constant demand throughout the day. Linen supplies will be required mostly in the morning; then housekeeping and dietary supplies, with others intermittent and less than daily.

As it is proposed to prepare dressings and trays in the supply room, the space nearest the point of departure should be planned as a workroom for this service, as well as the place of storage and dispensing of drugs and the less bulky medical and surgical supplies. Next distant should be clean linen supplies, then the bulkier medical and surgical supplies, stationary, etc. Dietary supplies should be kept in a separate room at lower than ordinary temperature, with bulk and barreled supplies farthest from the point of exit.

In planning the storeroom, first consideration should be given to making it easy to keep the room clean. Due to the handling of heavy boxes and barrels, the floor may be of concrete, but for ease and quietness it may well be of asphalt mastic, either laid in one piece or in the form of colored tile if appearance is a factor. It will be well to have the floor graded to one or more trapped drains so that the entire surface may be washed and flushed. As far as



Here is the way the author would set up a combination storeroom in a small hospital, to be operated as described in this article.

15 Years Ago—THIS MONTH—10 Years Ago

From "Hospital Management," November 15, 1917

First meeting of hospital superintendents, called to launch hospital standardization movement in Chicago.
Organization meeting of American Dietetic Association held in Cleveland.
News note reports new location of A. H. A. office in Washington, D. C., it having been removed from Philadelphia.

From "Hospital Management," November 15, 1922.

Some hospital meal costs reported at 1922 A. D. A. convention: 42, 43, 48, 36 cents for under 100 beds, 100-200, 200-500, and over 500 beds, respectively, and 76 cents for private patients.
1,012 hospitals on 1922 A. C. S. approved list.
Grinnell, Ia., Community Hospital begins hospital insurance for residents of community.

possible, all corners should be rounded and coved and all dust catching projections omitted.

Shelving, bins and drawers, if possible, should be of steel. These may be obtained from stock equipment to fit every space and need. When purchasing such equipment, thought must be given to ease in keeping it clean. Nothing should be permanently stored on the floor and the lower shelves should be high enough to permit cleaning underneath or the shelving should be set up on bases of concrete. A vacuum cleaner with proper attachments should be a part of the permanent equipment of such a storeroom and the person competent to operate this type of service will make good use of such equipment.

A sink with drain board will be a necessary part of the furnishing of such a supply room, and one made of stainless steel or Monel metal may be built into the shelving and cupboards. A metal sink of this type is easier on fragile glassware than the enamel iron or porcelain sink and is not ordinarily affected by the drugs or chemicals in common use. A hot plate, either gas or electric, will be required, and a water still is properly an item of equipment in this room.

The illustrations show how the storeroom in a hospital of about 50 beds may be arranged to attain the planned efficiency which will long pay good dividends on its first cost, in the form of good service and prevented losses.

Vertical transportation is by means of the passenger elevator not far from the storeroom door and by an automatic push button dumb waiter direct to the nurses' workrooms on the two patients' floors and the surgery above. Requisitions are dropped from a chute from these central points to the storekeeper's desk and

a speaking tube affords direct communication.

One central kitchen serving every need of this hospital is close to the storeroom. Perishable foods are checked through the storeroom direct to the kitchen refrigerators. The accounting and superintendent's office are on the same floor with the storeroom, as are the X-ray, laboratory and physical therapy departments and examining rooms.

Only equipment in most constant use will be kept on the floors above and all other equipment will be available from the storeroom, where it will be charged against the person using it, who is responsible for its return. Few or no drugs will be kept on the patients' floors and only the common stock solutions will be available in the nurses' workroom. A rigid system of exchange should be required for non-consumable articles.

Operating a supply room under such a plan, it is evident that charges to patients may be carried out to whatever detail the policy of the hospital demands and with comparatively few opportunities for error in charging.

Why Not Real Study of Insurance?

By Robert E. Neff

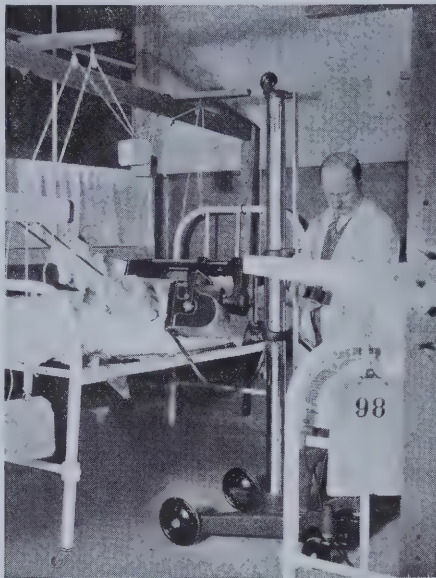
Superintendent, University of Iowa Hospitals, Iowa City

All should recognize the necessity of concerted and coordinated action in an attempt to work out a solution to the distressing problem in which our voluntary hospitals find themselves in this time of economic depression. The calamity is such as to command the immediate interest of the entire hospital field.

The circle of supporting philanthropists has in most hospitals diminished or has been diverted from hospital support to the more urgent call of emergency relief efforts. What can be done to prevent further diversion and to restore that supportive interest and concern on the part of philanthropists.

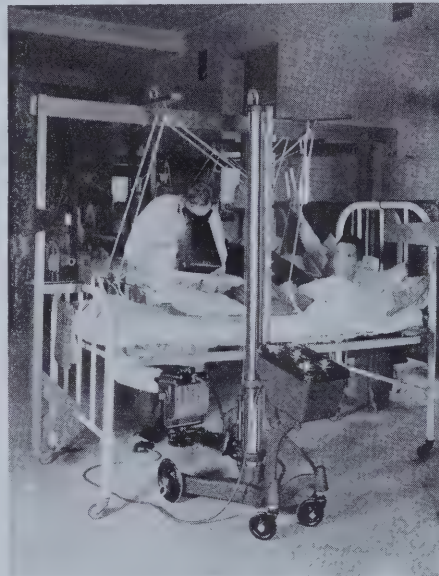
The changing distribution of wealth and the readjustment likely to come in the economic recovery makes us wonder whether we shall ever be able again to depend upon individual philanthropy for support of our hospitals as we have in the past. Rather pessimistic do we become when we note the possible ravages upon our organized public health and social agencies and institutions as a result of the present economic situation and the increasing popular clamor for the reduction of taxes. The present situation makes us wonder whether the taxpayer can be "educated" or reconciled in assuming larger responsibilities in the continuation of our social institutions.

With economic recovery will come a greater disposition and an ability on the part of the individual to help himself. The indigent we shall always have with us, for whom the government must provide, but with a system or plan which will point a way as an aid to the so-called middle class in helping them to help themselves, why not consider hospital and health insurance? The survey or study of a plan on a nation-wide basis by a committee representative of the hospital and allied fields and the various fields of commerce and industry would more than likely bring out a concrete method of insurance which could be offered to the average citizen as an aid to himself as well as to the hospital field in solving this perplexing problem.



Here are two scenes in the fracture ward of Cook County Hospital, Chicago, showing some of the uses of the newly developed shock-proof mobile X-ray unit. At the left shows the ease with which a lateral radiograph of a leg may be taken, and below shows the fluoroscopic of a leg fracture, with the tube directly under the bed.

This mobile unit utilizes the principles of the larger shock-proof models. Besides eliminating hazards of high tension wires and other handicaps of old models, this new unit, according to the manufacturers, makes apologies for poor quality of results unnecessary. Photographs courtesy of General Electric X-ray Corporation.



New Brunswick Hospital Tries Flat Rates

Type of accommodation	Flat rate (12 days)	Ordinary rate for comparison purposes	Rate per day for extra days
\$4.50 private room.....	\$60.00	\$ 73.00	\$4.58
\$5.50 private room.....	72.00	85.00	5.58
\$7.00 private room.....	90.00	103.00	7.08
\$3.00 semi-private room.....	40.00	52.50	3.12
\$2.50 semi-private room.....	35.00	46.50	2.71
\$1.75 ward (semi-public).....	25.00	37.50	1.87

The table above shows the flat rates for maternity patients recently put into effect at Saint John General Hospital, Saint John, N. B., reference to which is made below.

Dr. S. R. D. Hewitt, superintendent, Saint John General Hospital, Saint John, New Brunswick, thus comments on a question regarding flat rates for maternity patients which was asked by a reader (Page 15 of the last issue):

About six weeks ago we began such a system of flat rates for maternity patients, the details of which are shown herewith—the flat rates compared with the ordinary rates, and the charge for each extra day's stay. Flat rates, of course, include

the care of the baby and the case room, as does the figure mentioned in ordinary rates. Flat rates may be applicable only for a period of twelve days, and also only if paid at or before the time of admission, by which is meant, if the patient is admitted on Saturday, the twelve days' flat rate figure must be paid for then, and not the day after, and if not paid, the ordinary rates apply.

This has been in operation such a short time that no observations at the moment can be made, other than this: that the scheme has met with endorsement by obstetricians and patients alike, and we have had more private and semi-private patients this month than we have had for some considerable time. This may have occurred anyway, and a much longer time is necessary for observation, but I can see no reason why it should not be most suitable.

When this was adopted the physicians on the staff of the hospital were notified of the change and given a memo which they can keep on their desks.

Atlantans Consider Central School

At the recent quarterly meeting of the Georgia Hospital Association at Emory University Hospital, Atlanta, Miss Anna Feebeck, president, presided. Thirty-two members were guests of the hospital at dinner.

W. D. Barker, superintendent, Georgia Baptist Hospital, spoke on the financial problems of private hospitals, and J. B. Franklin, superintendent, Grady Hospital, who discussed legislation beneficial to hospitals. This was followed by a general discussion.

A motion was carried that the president appoint a committee to study the question of the establishment of a central school of nursing.

The president appointed the following committee to arrange for a central place for the future meetings: Mr. Franklin, chairman, Robert Hudgens, Mr. Barker.

The following committee was appointed to arrange the program for the next meeting: Dr. J. H. Hines, chairman, Miss Jessie Candlish, Miss Jane Van de Vrede, Miss Lillian M. Bischoff.

BIENNIAL MEETING

The dates of the next biennial convention of the American Nurses' Association, the National League of Nursing Education and the National Organization for Public Health Nursing are April 22-27, 1934.

Proposed Program for a Local Hospital Association

By J. DEWEY LUTES

Superintendent, Ravenswood Hospital, Chicago

WE should decide whether or not this association is to continue merely as an organization to hold meetings and discuss problems or whether it is to become an organization that will meet and overcome the situations confronting us. To realize our power is one thing, to use it is another.

To gain our position it is absolutely essential that we engage a well qualified full time executive secretary and establish a central office. You immediately say: What is the proposed program? Of what value is it to the hospitals? And how can it be done?

It is as important to this organization, even more so to individual local hospitals, to have a full time executive secretary with a program for the future as it is for the A. H. A. We must have someone who will give all his attention to the affairs of our association and direct an accepted program.

I feel that if our association would (1) put into operation the recommendations of the Committee on Public Relations it would warrant a central office with a well paid secretary and, in the course of time, show splendid returns on the investment. I shall not take the time to present any of the details covered by the 38-page report of the Committee on Public Relations. A copy may be obtained from the A. H. A. I would advise you to familiarize yourself with its contents.

The carrying out of this program would accomplish the following results:

I. (1) Creating good will which would simplify many of our present problems.

(2) Make it easier for hospitals to raise money.

(3) Tend to control the building of hospitals in communities where they are not needed. It would also tend to control commercial and non-hospital connected enterprises attempting to establish additional and unnecessary laboratory and other services which adds to the per capita cost in the hospitals.

(4) It would tend to strengthen the C. H. A. as an organization and possibly attract some philanthropic support.

This program was outlined at the October meeting of the Chicago Hospital Association and was referred to a committee for development. It is printed here because it suggests activities that might rather easily be carried out by a number of other local associations and state groups.

Veteran hospital administrators realize only too well that many of the problems facing local or state groups will never be settled on a basis of voluntary, part-time committee work. Whether or not the results sought are worth organized and properly supported effort is a question a few of the more progressive groups already are asking themselves.

There is no reason why a number of local and state associations should not successfully carry out a program such as Mr. Lutes outlines.

(5) Improve the relationship between doctor, hospital, nurses and the lay public.

(6) It would make possible the completion of any constructive work which our association may decide upon.

II. Standardized form for hospital reports.

Quoting a part of the report of the Committee on Plan and Scope of the A. H. A. as follows:

"Is it not high time for someone to develop a single system of annual reporting sufficient to satisfy the legitimate needs of the College of Surgeons, the A. M. A., and the numerous state and municipal boards that exercise legal supervision over hospitals? . . . Superintendents know only too well that the existing methods of multiple reporting is a waste and a nuisance!" I believe that a standard report to be used by all hospitals can be more easily adopted by each state or local association than by the A. H. A. because of the variation of local and state laws regarding statistical requirements. It should be a fairly simple matter to adopt a standard annual statistical

report for the members of the C. H. A."

III. A continuous survey of statistical data to show the distribution, demand, consumption and needs of hospital services within our boundaries.

IV. Effort and influence should be exerted to control hospital legislation by obtaining needed legislation and preventing harmful and contrary laws.

I hope that I have touched upon enough of the possibilities to stimulate your interest in discussion to the point that some benefit to our association and to the membership will be the result.

The expenses necessary for our work could easily be prorated to each member hospital on the basis of the number of patients admitted. After a survey to determine the total number of patients admitted annually by the member hospitals and after allowing a sufficient amount for the budget of the association, the assessed amount per capita could easily be determined and remittance made monthly to the association.

For example, if we had 50 member hospitals who admitted approximately 250,000 patients and the annual budget of the association was \$10,000, this would mean that each hospital would pay four cents per patient admitted.

PHOTOGRAPHER WANTED

The United States Civil Service Commission announces an open competitive examination for senior clinical photographer. Applications must be on file with the U. S. Civil Service Commission at Washington, D. C., not later than December 1, 1932. The examination is to fill a vacancy in the United States Veterans' Administration, Hines, Ill., and vacancies occurring throughout the United States in positions requiring similar qualifications. The entrance salary is \$2,000 a year, less a furlough deduction of 8½ per cent and retirement deduction of 3½ per cent. For this position the Veterans' Administration prefers a man. Full information may be obtained from the secretary of the United States Civil Service Board of Examiners at the post office or custom-house in any city, or from the United States Civil Service Commission, Washington, D. C.

WANT ILLINOIS LAW

Upon a question raised by C. J. Hassenauer, superintendent, Garfield Park Hospital, Chicago, in regard to a state lien law, the Chicago Hospital Association at its October meeting voted to support such a bill, and referred the matter informally to the legislative committee of the state association. Mr. Hassenauer has devoted a great deal of thought to the scope of a lien law and has had the advice and assistance of attorneys and others in drawing up a bill that is based on the experience of other states which now have such laws.

Information for Ten Purposes Obtained at Once

Centralized Clerical Work on Admission
Reduces to 61 Operations What Formerly
Averaged 549 Long Hand Operations
Daily at St. Louis City Hospital

By V. RAY ALEXANDER

Superintendent, St. Louis Hospital No. 1, St. Louis, Mo.

WITH a view of expediency and being mindful of the fact that the professional staff is required to do an infinite amount of clerical work in preparing histories, chronological developments, bedside notes, etc., we have centralized the routine clerical work incidental to a patient's admission and hospitalization.

It is to be emphasized that comparisons made herewith are based upon the use of the present coordinating system in St. Louis City Hospital No. 1 as against methods used prior to February 17, 1932, in the same institution.

The possibility of gleaning complete admission data is invariably greater upon arrival of a patient in the receiving room than at a subsequent time. The facts are fresh, the patient is anxious for admittance, accompanying relatives or friends assist in giving information, and personal effects afford verifications, identifications, etc.

Upon applicant's arrival, the receiving room physician makes a preliminary examination and indicates tentative acceptance or rejection as a patient. If in line for acceptance, a typist-clerk proceeds to work up immediately on a rough work sheet all general information except the admission diagnosis, the assignment to division, service and unit. While the patient is being bathed and dressed in, the typist-clerk types all data except as noted onto a master form. The printing on the master form, as well as the typewriter ribbon is of reproducing ink.

A social service investigator works simultaneously with the typist-clerk and if any non-medical features develop which might serve to preclude the patient's admittance, the facts are promptly submitted to the receiving room physician so that he may weigh the disqualifications against the imperativeness of hospitalization. Obviously, the final acceptance decision

In these days when superintendents are looking for time and labor saving ideas, some of them may find it possible to adopt the plan which has been in effect in this hospital since last February. This plan, based on the use of a duplicating machine, makes it possible to perform in 61 operations the equivalent of 549 long hand operations that formerly were done over varying periods up to 72 hours by people in five departments.

rests with the receiving room physician.

After being dressed in, the patient is presented to the receiving room physician who then makes the service assignment, based upon admission

diagnosis. The typist-clerk obtains assignment detail and completes the master form. The master form is then placed upon a hectograph machine constructed to insure perfect registration. The impression having been created, the reproduction onto the various forms is a matter of a few seconds.

At the present time, we establish with this system, the basic records for 10 original purposes:

1. Form No. 1—Patient's Record—History folder. Receiving room physician inserts receiving room data and signed history folder accompanies patient to division.

2. Form No. 2—Statistical Information. This form is placed in history folder, Form 1, and is available to junior intern upon arrival of patient on division.

3. Form No. 421—Visiting Physician. All visiting physicians sign in at information desk in main lobby. Cards are filed according to name of visiting physician and delivered by the information clerk when visiting physician signs in. This

SURNAME		GIVEN NAME	
STREET ADDRESS			
ADMISSION NUMBER		AT	
AGE		SEX	
RACE		SINGLE	
MARRIED		WIDOW	
SEPARATED		DIVORCED	
BORN ON		DAY OF	
CITIZEN OR		AT	
SUBJECT OF CITY		STATE	
COUNTRY		OCCUPATION	
EMPLOYED BY		FATHER'S NAME	
AND BIRTHPLACE		MOTHER'S NAME	
AND BIRTHPLACE		PATIENT'S TIME IN CITY	
LAST PREVIOUS ADDRESS		STRETCHER	
WALKER		CAME FROM	
CAME IN		ACCOMPANIED BY	
B. R. CLERK		RECEIVING PHYS.	
M. D.		PHYS.	
CONSCIOUS		CRITICAL	
BATH		RESTRAIN	
ADMISSION DIAGNOSIS		PRIOR HISTORIES	
IN CASE OF CRITICAL ILLNESS OR DEATH NOTIFY		RELATIONSHIP	
ADDRESS		AND PHONE NO.	
DIVISION		SERVICE	
UNIT		TIME OF ADMISSION	
M. D.		PHYS.	
DISCHARGED AT		TO	
M. D.		PHYS.	
TRANSFERRED		TO	
M. D.		PHYS.	
SUNDAY		MONDAY	
TUESDAY		WEDNESDAY	
THURSDAY		FRIDAY	
SATURDAY		SUNDAY	
DIV		PHYS.	

This form, typewritten once, is reproduced for ten different purposes in the statistical, clinical and other records of St. Louis City Hospital No. 1.

Here is a reproduction of one use of the master form, on an information sheet for the visiting physician. Note this form checked. A similar form with this information concerning the patient may be used for four other purposes, as the unchecked squares indicate.

4. Form No. 421—For Information Kardex. A Kardex record is kept at the information desk in main lobby. The information clerk on the 11 p. m. to 7 a. m. shift posts the patient's condition in the same manner as that described below as to Telephone Kardex. Data on this card provide assistance in directing and informing visitors. Upon the discharge, transfer or expiration of a patient, blank spaces are completed and the card is then filed in a vertical alphabetical file at the information desk.

When these cards have served their purpose at the telephone exchange, they are referred to the record librarian for statistical purposes. By filing the cards according to street address, we develop information as to the origin of our cases. A frequency often assists in detecting factors of interest. Localized areas suggest reallocations of outlying ambulance stations.

6. Form No. 422—Record Room—Alphabetical Index. The record librarian uses this card in the establishment of daily census reports as to divisions and services. Upon a patient's discharge, transfer or expiration, the card is completed on the basis of information in the history. The principal—final diagnosis, with corresponding Bellevue nomenclature code, as well as any secondary-final diagnosis is inserted and the card is filed in the permanent alphabetical index after cross indexes have been posted.

7. Form No. 423—Record Room—Numerical Index. An admission sequence record is maintained by binding these cards in strict numerical order. In order to dovetail all other records, it is neces-

sary to provide binding space to the right. This departure, having the suggestion of awkwardness, is not the handicap one might anticipate. Upon termination of hospitalization, data identical to that as posted to the alphabetical index are posted to this record, except that the final code and diagnosis is posted in the condition chart to the lower left.

8. Form 424—Social Service Department Index and Collection Record. The indexing of social service department records is accomplished by the alphabetical filing of this card. St. Louis City Hospital No. 1 is maintained by the city for the indigent. It is incumbent upon the staff to avoid accepting patients able to pay for private hospital care. Acute emergencies frequently place us in a position where there is no alternative, but to extend our facilities to the patient. In such an event, the social service department investigator subsequently works up information as to patient's current or contingent paying ability and a fixed charge per hospital day is collected if possible. The city

The indistinct upper left portion of this form shows where the master form information is printed on the history folder.

9. Form No. 424—Main Office—Ledger Card. Through the medium of insurance papers, civil and probate court proceedings as published in the Daily Legal Record, authorized perusal of patient's record by attorney for the injured, and from many other sources, we are able to obtain leads pointing to the ultimate collection of our hospital bill. In such cases, the main office is able to maintain a counter-check against the collection efforts of the social service department.

10. Form No. 425—Social Service Record—Work Sheet. Social service workers stationed in the receiving room work up data while patient is being admitted. This form is then submitted to the typist-clerk so that 5"x6" imprint in upper left hand space can be made along with all other forms mentioned above.

Our daily admissions averaged 61 for the fiscal year ending March 31, 1932. Under our prior method of recording, it was necessary to prepare at various stages, the following:

A. Long hand preparation of memo slips for the Record Room. By record clerk

B. Long hand data on patient's record.
Form 1. By receiving room physician.

Form 2. By junior intern.

D. Long hand data for Information Kardex, name typewritten later. By nurse in charge.

E. Long hand data for Telephone Kardex, name typewritten later. By nurse in charge.

F. Long hand entries in general information index, bound volume. By record clerk.

G. Long hand entries in numerical index in Record Room, bound volume. By record clerk.

H. Long hand preparation for Social Service Form 283. By social service worker.

I. Long hand preparation of Social Service Form 13. By social service worker.

Which reflects an average of 549 long hand operations daily.

Items A, F, G, H and I were transcribed from a 24-hour admittance sheet written in long hand. Sundays and holidays would often delay the complete preparation of all records except items B and C for a period in excess of 72 hours. The accumulation would then be overwhelming and oftentimes the patient had left the hospital before complete records had been set up. The reaction was most damaging to the information desk, the telephone service and to the entire staff. Forms A to I, inclusive, were not standardized in any respect, and each person, after a fashion, would write the record. Important data was eliminated on some records, surnames were confused with given names, names were spelled many different ways and chaos ruled supreme.

Our current master form has a reproducing area of 5 by 6 inches. It serves our purpose advantageously. A rearrangement can be effected

whereby records 3 by 5 inches, 4 by 6 inches, 5 by 6 inches or any other combinations, graduating, if desired, up to the size capacity of the hectograph machine may be had.

Upon the exhaustion of our present blank supply of bedside notes, drug orders and laboratory requisitions, the forms will be altered so as to permit the immediate heading of the initial sheet in each instance. Here again flexibility permits a reproducing area confined to a limited space. We shall provide a space 1

by 6 inches to accommodate surname, given name, street address, admission number, time and date of admission and division.

We consider further expansion of the system in the matter of preparing papers for the Bureau of Vital Statistics as to new-borns, the reporting of communicable diseases to controlling health agencies, routine data to the Social Service Exchange, statistical data relative to any hospitalization of United States Veterans, and to other selective causes.

should overlap, as it were, and each department can do its share. All that is required is a little additional forethought on the part of the employees, who are or should be endowed with the average amount of good common sense that only needs to be exercised. Suggestions for the interest of the institution are welcome at all times.

The fundamental thing to be considered is service—the best that we can give, with the minimum amount of loss from any source. A few of these losses are faucets left on and water running when not in use; electricity left on when not needed; tearing and cutting linen and wearing apparel. The hoarding of linen is a common error. Wards in need of special linen should requisition only the required amount, and no more. In some instances linen is “put on the shelf for further use.” Some other ward in this way is deprived of the use of these articles during the interval. In this way a supply commensurate with the needs of the institution can be on hand at all times. In order to avoid the tearing of linen for cleaning purposes, colored cloths are used throughout (blue is preferable—in this way old uniforms can be utilized).

Celluloid envelopes bound with white tape, having a loop at the top so that they can be hung up (open at the top for the insertion of lists, rules, etc., for ward personnel), keep the lists looking fresh and add to the neat appearance of the office or cupboard in which they are placed. A printed list of duties for porters hung in this manner in all porters' closets serves as a constant reminder of their respective duties. Among other things, porters are cautioned to be respectful at all times, to help lift a patient in an emergency, to wear all keys on a chain attached to his clothing (especially dormitory porters), thereby eliminating the loss of keys, which are sometimes left in doors, to report promptly for duty, and to be responsible to the housekeeping department only for orders. A weekly conference with the porters is held in the office of the housekeeper for the purpose of discussing points of interest for the benefit of all.

The scope of the housekeeping department is far-reaching, as there are so many side issues dependent upon it—the waxing and polishing of all floors, for which the latest type of electric machines are used; the replacing of curtains which were removed from windows that have to be cleaned (one hospital has about 5,000 windows in need of constant attention), and various other duties.

Some Housekeeping Problems in a Large Hospital

By ROSE J. FOLEY

THE housekeeping department is one of the most important divisions of any large institution, inasmuch as all departments and wards are dependent on the systematic, prompt and efficient manner in which it is conducted. Discipline and system are two very important factors.

An executive of one of our large institutions was criticized for making the statement, “A housekeeper can make or break an institution.” His criticism, however, has since been refuted. As a matter of fact, the housekeeping department is the hub of the entire institution, and each ward is a spoke in the wheel. If the wheel revolves smoothly and evenly on this hub, order and service are the result, but let the hub cease to function properly, and everything else is affected directly and indirectly.

The work in the linen room should be so systematized that interruptions caused by the closing down of the laundry, for one reason or another, will make no apparent difference in the delivery of supplies to the wards. These supplies are listed on printed forms and are placed on trucks marked for the respective wards, to which they are taken by the porters when they report for duty in the morning. The charge nurse then checks the printed form and signs for the linen. She also signs for all special requisitions thereafter, as all articles distributed are on an exchange basis only. In this way we obtain an actual count of the pieces delivered daily and on which we rely for our monthly report of the number of articles distributed for over 1,000 beds. A bright, cheerful linen room, with plenty of fresh air and

sunlight, goes a long way toward giving “service with a smile” and makes for happy, contented employees.

In the matter of changing uniforms, coats, etc., a stagger system has been very effective. Orderlies, porters, and others are given an appointed time on certain (different) days, when exchanges are made. This relieves the congestion that might otherwise be caused when too many people call for exchanges at one time. One system that has proven very successful in doing away with the loss of uniforms is the following: On the receipt of a clean uniform, the employee leaves his identification card (all employees receive an identification card at the time they are engaged) which is returned to him when the soiled unit is brought back. (A suitable room is supplied for changing uniforms.) In this way it is easy to determine who is not returning uniforms. When the employee is discharged, this same card is marked, “uniform returned.” Anyone whose card is not so stamped is charged for his uniforms. The result is that the institution suffers no loss from this source.

It is, of course, necessary that all departments cooperate in order to obtain the best results. There should be no dividing line. All departments



Former housekeeper, Montefiore Hospital, New York

WHO'S WHO IN HOSPITALS

THE Quarter Century Club, which ought to be, if it is not, an actual organization, recently would welcome into its exclusive membership Mrs. Mary Stone Conklin, who for 25 years has been superintendent of Hackensack, N. J., Hospital. The happy occasion was marked October 1 and Mrs. Stone was guest of honor at various functions, including dinners by the medical staff and nursing school alumnae, as well as recipient of continued good wishes from trustees and others interested in the hospital. It is interesting to note that Mrs. Conklin holds a record as a "temporary superintendent," as she took charge of the hospital in that capacity 25 years ago and has been there ever since. A unique feature in connection with Mrs. Conklin's silver jubilee is that the assistant superintendent of Hackensack Hospital, Katherine MacLeod, entered the school of nursing the same day Mrs. Conklin became hospital superintendent. Proper recognition of Mrs. Conklin's long and successful administration was given her by various officials of the hospital and others in a recent issue of the Hackensack Hospital Quarterly Bulletin.

Camille Sonnefeld resigned November 1 as superintendent of Community Hospital, Geneva, O.

Dr. T. R. Ponton, superintendent, University of Georgia Hospital, Augusta, and a well known figure in the field, resigned, effective October 21, and Dr. L. P. Holmes, director of X-ray at the medical college, was named to succeed him temporarily.

The new manager of the hotel and tearoom department of Methodist Hospital, Indianapolis, Ind., is Mrs. Esther Fraser, a graduate of Indiana University. Mrs. Fraser recently completed a post-graduate course offered by the hospital dietetic department, under the direction of Mrs. Margaret D. Marlowe, executive dietitian.

The new superintendent of nurses at the Methodist Hospital, Memphis, Tenn., is Nina Wootton, formerly with Peoples Hospital, Akron, O. Miss Wootton succeeds Georgia Holmes, who resigned after twelve years.

Dr. H. A. LaMoure, for several years superintendent and medical director of the Woodcroft, Colo., Hospital, resigned effective November 1.

William B. Seltzer now is super-



MARY STONE CONKLIN
Superintendent, Hackensack Hospital,
Hackensack, N. J.

intendent of the Bronx Hospital, Bronx, N. Y., succeeding William S. Sindey, who resigned after eight years of service. Mr. Seltzer was affiliated with the hospital from 1922 to 1924 as accountant and for the next five years was assistant superintendent of Mt. Sinai Hospital, Philadelphia. He returned to the Bronx Hospital in 1930 as assistant superintendent.

Catherine Balkema, formerly with Putnam County Hospital, Greencastle, Ind., is X-ray and laboratory technician at the Bloomington, Ind., Hospital.

Agnes Hickman resigned November 1 as superintendent of the Anna, Ill., City Hospital.

Ida Larson has resigned as superintendent of the Perry, Iowa, Hospital to take charge of the new Reedsburg, Wis., Municipal Hospital.

Theresa M. Hayes, formerly with the Community Hospital, Amherst, O., has been appointed superintendent of the Lodi, O., Hospital.

The board of trustees of Methodist Hospital, Peoria, Ill., recently named Flossie Graves superintendent. She has been acting superintendent for several months.



Miss E. Irene Perry, formerly supervisor of Metropolitan Children's Hospital, Welfare Island, New York, has been appointed directress of nursing of the Municipal Hospitals, Haverhill, Mass.

David C. Adie has been appointed commissioner of social welfare of New York, succeeding Charles H. Johnson, who resigned after having served in this capacity for 16 years.

The La Rabida Sanitarium for Crippled Children, situated on a peninsula in Jackson Park, Chicago, was opened October 18. Zella Taylor is superintendent.

Elizabeth I. Hansen recently was appointed superintendent of Harrington Memorial Hospital, Southbridge, Mass.

Laura Belle Wilson, for three years director of nursing at St. Margaret's Memorial Hospital, Pittsburgh, has been named superintendent of the Children's Hospital, Pittsburgh.

Mrs. Pearl Rexford has resigned as superintendent of the Northwestern Hospital, Minneapolis, Minn., after twelve years of service.

Rev. C. Q. Smith has re-entered the ministry and has resigned as superintendent of the Methodist Hospital of Ft. Worth, Texas. He formerly was president of the Texas Hospital Association.

George W. Olson, who resigned as superintendent of the California Hospital, Los Angeles, Cal., recently after having served in that capacity for ten years, has accepted a position on the administrative staff of the Los Angeles General Hospital.

William Mills, widely known in the field, recently resigned as superintendent of Swedish Hospital, Minneapolis. Mr. Mills served as secretary of the Minnesota Hospital Association for a term and also is a former president of the Minneapolis Hospital Council. During his time as superintendent, the Swedish Hospital grew from 200 beds to 350 beds and completed an extensive construction program. Mr. Mills formerly was assistant to George W. Olson and became superintendent when the latter resigned in 1919.

Mercedes Johnson recently was appointed dietitian at St. Joseph's Mercy Hospital, Pontiac, Mich. Miss Johnson is a graduate of the University of Minnesota and took post-graduate work at the Clifton Springs Sanitarium and Clinic in New York.

1929-1931 Comparison of 29 New York Hospitals

THE accompanying figures from a study by the United Hospital Fund, New York, Homer Wicken- den, director, will prove of interest to many. The table above represents a comparison of service of 29 general hospitals in 1929 and in 1931, with a comparison of the patient day cost for the two years. The lower table shows the earnings of these same hos- pitals and the expense for serving the patients. It is to be noted that the earnings include city payments for service the hospitals rendered to those for whose care the city was respon- sible.

For each of the hospitals the total number of patient days and patient day cost is given for the two years, also the total expense of the care of the patients and the amounts paid by the patients. These figures will serve to enable interested readers in hospitals with approximately the same volume of service in patient days, to compare roughly their own expenses, costs and revenue from patients.

It is to be noted that the average income from patients decreased 3.1 per cent and the hospitals were able to cut costs only .2 per cent. In round figures, these hospitals cut costs only \$43,000, while income

from patients dropped \$370,000. Fif- teen of the hospitals reported in-

creased patient day cost, compared with 1929, and 14 decreased cost.

The increased earnings from pa- tients may be accounted for in some instances by allotments from the city for indigents. Incidentally only seven of the hospitals showed such in- creased earnings.

HOSPITALS—	1929	1931	PATIENT DAYS		1929	1931	
			In-crease	De-crease		In-crease	De-crease
1. Beekman Street	26,086	25,696	...	1.5	\$ 7.07	\$ 7.10	...
2. Beth Israel	48,207	93,931	94.8	...	11.77	...	6.92
3. Beth Moses	67,120	63,655	...	5.2	6.05	...	5.20
4. Bronx	29,004	30,810	6.2	...	6.62	6.91	...
5. Brooklyn	88,319	76,127	...	13.8	5.96	6.94	...
6. Community	31,404	16,365	...	47.9	4.66	7.30	...
7. Fifth Avenue	80,742	66,596	...	17.5	7.26	...	6.94
8. Flower	56,583	60,035	6.1	...	9.14	...	6.70
9. French	46,603	54,089	16.1	...	6.67	...	6.61
10. Jewish	150,684	167,079	10.9	...	7.10	...	5.44
11. Knickerbocker	46,791	44,999	...	3.8	6.22	6.59	...
12. Lebanon	50,374	49,916	...	.9	6.28	...	6.07
13. Lenox Hill	99,855	95,960	...	3.9	9.15	...	6.58
14. Long Island College	142,434	127,862	...	10.2	4.85	5.08	...
15. Methodist Episcopal.	129,375	130,747	1.1	...	5.15	...	4.36
16. Misericordia	85,154	77,534	...	8.9	3.82	...	3.61
17. Mount Sinai	198,319	190,384	...	4.0	7.47	7.51	...
18. New York (Main) . . .	94,248	90,706	...	3.8	7.38	7.81	...
(Branch)	27,281	27,993	2.6	...	2.54	...	2.47
19. Norwegian Lutheran	60,097	58,997	...	1.8	4.18	4.32	...
20. Polyclinic	84,015	83,704	...	.4	5.90	6.82	...
21. Post-Graduate	110,949	103,685	...	6.6	8.48	...	7.97
22. Presbyterian	248,553	241,668	...	2.8	7.91	10.05	...
23. Prospect Heights . . .	37,827	34,894	...	7.8	6.05	6.34	...
24. Roosevelt	90,693	87,588	...	3.4	6.48	7.73	...
25. St. John's, Brooklyn	41,550	54,886	32.4	...	6.77	...	5.63
26. St. Luke's (Main) . .	139,315	133,005	...	4.5	6.64	6.81	...
(Branch)	26,822	28,481	5.8	...	3.98	...	3.46
27. St. Mary's, Brooklyn	71,173	75,806	6.5	...	4.89	...	4.62
28. Sydenham	57,039	49,517	...	13.2	7.04	7.42	...
29. Wyckoff Heights . . .	52,463	50,540	...	3.7	6.17	...	6.04
Total	2,519,129	2,493,255	...	1.0	...	...	...

EARNINGS FROM PATIENTS (Board and special charges including city payments)

HOSPITALS—	1929	1931	EXPENSE OF PATIENTS		1929	1931	EARNINGS FROM PATIENTS	
			Per cent Increase	Per cent Decrease			Per cent Increase	Per cent Decrease
1. Beekman Street	\$ 184,512	\$ 182,475	...	1.1	\$ 132,195	\$ 105,469	...	20.2
2. Beth Israel	567,693	649,799	14.5	...	244,712	416,370	70.1	...
3. Beth Moses	405,927	331,261	...	18.4	315,167	289,731	...	8.1
4. Bronx	191,934	168,750	...	12.1	135,785	143,211	5.5	...
5. Brooklyn	531,849	528,598	...	.6	407,265	344,670	...	15.4
6. Community	146,709	119,421	...	18.6	178,678	127,789	...	28.5
7. Fifth Avenue	586,064	462,217	...	21.1	455,422	345,577	...	24.1
8. Flower	447,403	401,957	...	10.2	360,661	295,060	...	18.2
9. French	310,781	367,183	18.1	...	220,908	301,689	36.6	...
10. Jewish	1,071,863	908,983	...	15.2	974,967	1,049,053	7.6	...
11. Knickerbocker	291,155	296,334	1.8	...	241,810	209,388	...	13.4
12. Lebanon	316,405	302,901	...	4.3	180,029	159,121	...	11.6
13. Lenox Hill	671,300	631,778	...	5.9	565,576	473,925	...	16.2
14. Long Island College	668,367	649,553	...	2.8	635,465	581,432	...	8.5
15. Methodist Episcopal	661,612	570,460	...	13.8	497,134	482,308	...	3.0
16. Misericordia	325,134	279,801	...	13.9	263,068	234,223	...	11.0
17. Mount Sinai	1,480,537	1,430,608	...	3.4	888,408	772,381	...	13.1
18. New York (Main)	606,274	708,702	16.9	...	433,923	428,676	...	1.2
(Branch)	69,358	69,005	...	.5	0	0	...	...
19. Norwegian Lutheran	251,434	254,706	1.3	...	247,704	228,589	...	7.7
20. Polyclinic	529,574	570,606	7.7	...	639,014	645,265	1.0	...
21. Post-Graduate	940,902	826,876	...	12.1	804,419	627,935	...	21.9
22. Presbyterian	1,966,805	2,429,671	23.5	...	1,122,188	1,416,850	26.3	...
23. Prospect Heights	228,720	221,223	...	3.3	219,585	209,927	...	4.4
24. Roosevelt	581,169	677,593	16.6	...	329,740	303,738	...	7.9
25. St. John's, Brooklyn	281,457	308,803	9.7	...	159,848	201,949	26.3	...
26. St. Luke's (Main)	924,339	905,936	...	2.0	564,802	534,992	...	5.3
(Branch)	106,854	98,694	...	7.6	16,011	11,801	...	26.3
27. St. Mary's, Brooklyn	348,167	349,463	.4	...	285,328	282,583	...	1.0
28. Sydenham	401,487	367,444	...	8.5	382,302	347,412	...	9.1
29. Wyckoff Heights	323,513	305,234	...	5.7	296,966	247,234	...	16.7
Total	\$16,419,298	\$16,376,035	...	.2	\$12,199,080	\$11,818,348	...	3.1

THE HOSPITAL ROUND TABLE

Another Cross Index

The superintendent of a municipal hospital in a large city in showing a visitor through the record department recently called attention to a new system of cross indexing of records which was in use. Under this system the records were filed by street address. Of course, the alphabetical index, the index by disease, and the numerical index also are kept, but the street number was suggested by the fact that on several occasions when a patient was driven home in the hospital ambulance the people at the address given refused to admit the sick person, explaining that the address had been used by the patient only to establish legal residence in the city and thus to make the patient eligible for free service. Perhaps this same fraud may be practiced on municipal hospitals in other large centers.

What Price Bandits?

The superintendent of a hospital in a large city in which a number of hospitals have been robbed recently remodeled the cashier's and telephone operator's offices to make them bandit-proof. Among the protective devices are bullet-proof lead glass windows, burglar alarms in different parts of the offices which may be operated by foot pressure, steel doors, and bullet-proof screens for windows, etc. One visitor who was shown these precautions wondered how the maintenance of the equipment and the cost of the 24-hour special police protection was entered into the cost of operation. "It's only another proof of the fact that you must know a great deal about a hospital before you can begin to compare one institution with another on the basis of patient day cost," was the comment.

New Kind of Models

While the use of models of foodstuffs to give a visual idea of size of portions, etc., is not new, yet many hospitals and out-patient departments have been unable to make use of these models because of the cost or the unavailability of an artist to prepare the models. One hospital recently learned of a process of mummification which has been rediscovered abroad and suggests that the

mummification of actual portions of foodstuffs of proper size and weight, etc., might be used instead of the wax models. A few hospitals are using human organs and portions of bodies, mummified, for teaching purposes.

Test Respirator

Mt. Sinai Hospital, Chicago, Maurice Dubin, superintendent, routinely tests its infant respirator as part of the technique of setting up a birth room. It is the belief of Mr. Dubin that equipment such as a respirator which is used only infrequently and which must be ready instantly when it is needed ought to be in condition to function when it is wanted. By testing the equipment as the room is being prepared for a patient the personnel know that the equipment is ready to work, or if it is not ready, the personnel are in a position to summon help to have the repairs made.

No Superintendent's Report

In looking through a recently received annual report of a hospital it was noted that the report of the superintendent was not included. Various officers of the board summarized the more important accomplishments and activities in which they were interested, but no space was given to anything that the superintendent might have wanted to say. Is this a development of present economic conditions?

More Guest Cards

Another hospital which finds the use of "guest cards" helpful is Toumey Hospital, Sumter, S. C., Charles H. Dabbs, superintendent. "We find this idea meeting with such popular approval that we think other hospitals may be interested," writes Mr. Dabbs. "The card helps in two types of cases; where rather too many flowers are sent it is a happy substitute, and where real help is appreciated, such as by the 'white collar' class and the poor. From the hospital's standpoint the card stimulates wholesome interest of the right person or group—the thoughtful."

The Toumey Hospital guest card is approximately 3½ by 5½ inches,

with the following message neatly printed:

GUEST CARD

Dear:

Your hospital charges for today have been paid by and we are asked to let you know that you are guest for the day.

The thought behind this little gift is that since you cannot be a house guest and will doubtless receive other tokens of affection while you are in hospital, your host wishes to show you the next nearest hospitality to that which it would be their pleasure to show in their own home. If this slight token gives you even the least pleasure or comfort, our only other wish is for a speedy recovery.

Date.

Library Service

A. G. Hahn, business manager, Deaconess Hospital, Evansville, Ind., recently spoke before the Indiana Library Association. He said that hospitals expect from librarians:

Attractive and clean books.

Books familiar to librarian.

Classes to suit all.

Service for personnel and nursing school.

He also said that the hospital family includes the librarian, and that she should have the same ethical standards as a nurse.

The library, according to Mr. Hahn, expects from the hospital a home for books, locked, clean, comfortable, convenient to work in, and that only books charged by the librarian should be taken. Cooperation of supervisors and promptness in returning books were other things the hospital should obtain for the library.

Dietitian-Nurse

The superintendent of a small hospital recently made an effort to find a nurse who also was a graduate dietitian in order to have proper supervision of the dietary department and thus help the hospital move towards its goal of complete approval by the American College of Surgeons. The search was in vain, however, as, while many housekeeper-dietitians were discovered, the only dietitian who had received a nursing education and who therefore could properly qualify both as a dietitian and a nurse was located in a large hospital. And strange to say, this person was not there employed either as a dietitian or as a nurse, but was most satisfactorily carrying on as assistant superintendent!

COMMUNITY RELATIONS

Do You Know If a Patient Will Come Back Next Time?

Here Are a Few Simple, Inexpensive Things That Many Hospitals Can and Should Do to Please Patients and Relatives and Build Up Good Will of Vast Importance

By B. P. MOFFATT

Methodist Hospital, Memphis, Secretary Tennessee Hospital Association

IN these times of financial depression, when patients are few and cash is scarce, every hospital is vitally interested in adjusting its budget to the requirements of the situation. Many ways have been suggested, general expenses have been materially reduced, salaries have been cut, employes put on part-time, and still in many cases the problem is difficult. We must adjust ourselves necessarily, but we must not lower the standard of service rendered the patient.

We are called on to give a service that will please the most exacting surgeons as to its technique, to give a service that will excel that offered by a first-class hotel to please the patient and the patient's family, and also to carry the load of much free work, and all on a reduced budget.

I believe that if our institutions will adopt certain policies that have proven beneficial to many large corporations, that it will be of great value to us, not only now but also in the future.

Would it not be worth while to educate the public as to just what hospitals offer, and also the handicaps under which many of them work? In so doing to build up good will for our hospitals? Many department stores and retail establishments offer merchandise at prices below cost in order to get people inside their doors. Many large corporations employ high salaried men to contact the public and to maintain personal touch with them.

While perhaps we could not change the phrase, "The customer is always right," and say that the "Patient is always right," yet I believe we could build up for ourselves something that money could not buy, something that would be valuable at all times, but especially valuable in

times like the present—the good will of the public.

How can this be accomplished? The following might help:

First. By "selling" your hospital to every patient that enters your institution.

Did you ever check and see if your patients left you pleased with your hospital?

If a second hospital stay should become necessary, would they return to your hospital?

Were the members of the family pleased with the treatment received by the patient?

Is your ex-patient a booster or a knocker?

Check and answer these questions, and if the result is not as it should be, then seek the cause. While it is true that patients and their relatives are usually very unreasonable in their demands, we must realize that the general public is not sufficiently "hospital educated," and that every one concerned with a patient is under a severe nervous strain, and realizing this, if we could coach the personnel of our institutions to render a pleasing service, in making gracious refusals to impossible requests, in rendering all services with a smile—in other words, get everyone, from the

telephone operator to the supervisor, interested in trying to sell the hospital and its service to the patient, then we would certainly obtain the most favorable impressions.

Second. By some special concerted efforts. They are small things, it is true, but they count, and the people appreciate them. A little card of welcome on the first tray served, a flower on the tray on Easter, a suitable decoration at Christmas, perhaps the local paper furnished every day, a call from the superintendent or the superintendent of nurses at least once during the stay in the hospital, for everyone likes to be noticed. Perhaps a follow-up letter after the patient reaches home, inquiring as to his welfare. And especially if a maternity case, send the baby a greeting card on its first birthday. This will make the mother a booster for life. Such little attentions like these do not cost much, but they are deeply appreciated and certainly can do your hospital no harm.

Third. We can accomplish the same thing by proper publicity. You will find the newspapers and reporters always more than willing to help you. Join up with your local and state organizations and push National Hospital Day. Link up your hospital with this movement. Tell your papers your news, tell them the interesting things about your work, and especially let them know about that case in your hospital that will touch the hearts of the public. Let people know how much free work you are doing, and just what it costs you, for many people have the idea that hospitals are mere machines for grinding out profits. Let folks know the facts, and you will be surprised at how they will want to help you. Much good can be done by properly supervised publicity.



Want Articles About Hospital in Your Local Press?

IF you want something about your hospital in your local press, something that will help to explain some of your problems and that will create a favorable attitude toward the hospital, then do this:

Make a copy of each of the articles published on this page, one copy for each weekly or daily newspaper or other publication in the area from which you receive patients. Fill in the facts and figures suggested. Send a copy to each editor around the time suggested at the top of the article. You will find that most editors will be glad to get this material and in some instances they will put it on page one, or use it for editorial comment of a favorable nature.

Hospitals large and small in many states are using these articles every month. This is a splendid publicity service for you, with an article each week.

HOSPITAL MANAGEMENT is the only paper to offer its readers this practical service.

Don't forget to send us clippings from the papers after the articles appear:

Here are the articles:

Surgeons Agree on Value of Management

(Week of November 15)

At the recent conference of the American College of Surgeons a most important announcement was made in regard to the management of hospitals, . . . (name), superintendent of . . . (name) Hospital, said yesterday. The College which annually inspects nearly 3,500 hospitals in the United States and Canada to study their professional organization and other features that reflect the kind of service they render to the sick, announced at this meeting that able, experienced superintendents were an important factor in a good hospital, and the College added that a number of hospitals were not acceptable to it because their superintendents were inexperienced and had not yet proved their ability. This is the first time an authoritative statement, backed by this kind of action, has ever been made, although for a long time it has been recognized that the management of a hospital is a vocation that requires special knowledge and training. The College is expected to con-

tinue this policy, according to the superintendent, and this means that in the future hospital boards will be expected to inquire much more closely into the records of the man or woman to whom they entrust the management of their institution.

Hospitals Are Cause For Thanksgiving

(Week of November 21)

Many people may feel that they have little to be thankful for this Thanksgiving, said . . . , superintendent, . . . Hospital, yesterday, but the superintendent then proceeded to point out that the community that has a progressive hospital has a great deal to be thankful for. Hospitals should not be judged solely by the number of patients they serve, it was pointed out—although this is a good measuring rod—for hospitals encourage doctors to keep abreast of modern medicine, provide new equipment, and in short, try to assure the community the most improved service. It must be remembered, too, that only a few of a doctor's patients need hospital care, and the new ideas of treatment, the new methods, etc., are carried into the homes and thus the hospital benefits many times the number of its patients in the course of a year.

Injuries, illnesses and many conditions which because of the facilities of the hospital and the up-to-the-minute knowledge of the staff remain trivial by prompt and effective treatment, would get beyond the trivial stage, said the superintendent, and some of them would prove fatal were it not for the hospital.

Speaking of Thanksgiving, the hospital always observes this day with appropriate menus and trimmings. This year those patients able to partake of a full meal will have: (insert Thanksgiving menu).

Hospital, Not Hotel, Meets Needs of Sick

(Week of November 28)

"Every once in a while one tries to compare costs of hospitals and hotels and says a hospital is like a hotel," said . . . (name), superintendent of . . . Hospital, yesterday. "Well, here are a few departments of a hospital which are not to be

found in a hotel: laboratory, special diet service, general nursing, routine medical care, X-ray, between-meal nourishments. Such departments as these, moreover, bring trained specialists or expert workers directly into personal contact with a patient. If a person were sick in a hotel, none of these services would be as readily available or as expertly rendered as hospitals perform them. In brief, a hotel is like a hospital only up to the point where hospital service begins, and from that point on, of course, come the services that the patient needs and which only hospitals offer."

Fairer Rates for Hospitals Seen

(Week of December 5)

Among the many results which the prolonged unfavorable business conditions will bring about after their readjustment, according to . . . , (name), superintendent of . . . Hospital, is a fairer rate to hospitals generally for their service to industrial workers and to victims of accidents, as well as to indigents for whose care a city, town or county is legally liable. This topic of fair rates has been frequently discussed at meetings of hospital executives, said the superintendent, and there is a general belief that the different hospitals, through their associations, must insist on a proper rate from those responsible for paying the bills when the patient is not able to pay for himself.

A very important result from a fairer rate to hospitals is that the public, who in the end must help the hospital carry its financial burden, will not be called on so frequently. In other words, if hospitals are paid cost for service to an injured employe or to an accident victim who receives insurance or damages because of the accident, then the hospital will be in a much better position to balance its budget each year than now, when a majority of such patients either must be cared for free or at a nominal sum which does not begin to meet the cost to the hospital. The . . . Hospital, for instance, in an average year is asked to care for (number of indigent, industrial, accident patients, etc.) either free or much below cost. This has resulted in a loss of \$. . . to the institution, says the superintendent.

DR. ANDERSON DEAD

Dr. Albert Anderson, who had been superintendent of the State Hospital for the Insane, Raleigh, N. C., for nineteen years, died recently.

Fire Prevention and Safety Program of One Small Hospital

Detroit Industrial Hospital Highly Organized to Protect and Remove Patients in Case of Fire Hazard

By WALTER GRAVES

THE safeguarding of human life in the case of fire is one of the paramount responsibilities of the management of hospitals.

The principal function of a hospital is the saving of human life, and it must be so managed as to remove all danger of its functioning negatively.

The management of the Michigan Mutual Hospital, Detroit, has realized its responsibility, and after extensive study has adopted precautions that constitute solutions of the various specific problems.

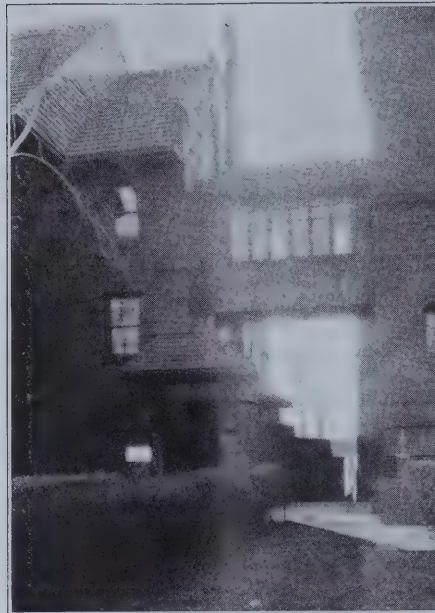
Fire prevention measures consisted in the removal of all celluloid films to ventilated fireproof storage cabinets in a detached building, installation of apparatus for the humidification of the operating room (to remove all chance of static electricity discharge) and other necessary precautions to prevent an explosion of an anesthetic; also to maintain faultless housekeeping in basement and all storage rooms to preclude the possibility of spontaneous or other ignition of material of any kind.

Life-saving measures consisted in providing two fire escapes from the second story wards of such type that stretcher-borne patients could be quickly and easily wheeled or carried to safety. Also the quick assembling of two adequate groups of trained helpers as outlined in detail later on.

One of these fire escapes consists of a covered passageway at second floor level in connection with the out-patient building and nurses' quarters, and is equipped with double smoke-proof fire doors. Both doorways were constructed of extra width to facilitate the passing of hospital beds.

All hospital mattresses are specially made and covered with a heavy cover, attached to which are strong hand-hold straps of canvas to facilitate their being moved or carried.

The ward rooms and corridors are provided with emergency wall lamps



"A covered passageway at second floor level, equipped with double smoke-proof doors."

in which current is supplied by batteries (which are replaced every 90 days), thereby avoiding panic or any delay in the preparation or rescue of patients should the lights go out in the building.

Realizing that a means of escape must also be provided at the other end of the building in the event the

covered passageway were cut off by smoke or heat, the tubular fire escape was adopted as the only logical type that would meet the requirements. This escape is specially designed and built to take the standard hospital mattress, patient and all, and deliver to the ground level without the slightest jar or danger. The upper and lower ends of this tubular escape, and also the rear yard of the hospital, are lighted by lamps on an outside circuit.

The yard wall enclosure is provided with ample openings to enable firemen to approach from the rear and to work unhampered by wires or obstruction of any kind without interference from the public traffic on the front street.

The removal of patients in the convalescent ward offers no special problem as the ward is located on the first floor. The room has two exits, one of which leads out-of-doors. These patients are able to get about unaided.

The removal of second-floor patients involves a problem peculiar to hospital fires. The task consists of two separate and distinct parts: the preparation of all patients for removal and their actual removal.

It was decided that the former work could only be handled properly by the regular trained hospital personnel of surgeons, nurses and interns, all of whom are domiciled on



The Michigan Mutual Hospital, Detroit, where fire precaution and safety program described has been put into effect.

Consulting engineer, Michigan Mutual Liability Company, Detroit, Mich.

the premises, and are subject to quick mobilization.

The preparation of patients involves bundling up, transfer of supports, and perhaps other important surgical and medical attention.

The force available for this work, which is summoned by a hospital alarm turned in by the night surgeon or night nurses upon the first intimation of trouble of any kind, seemed ample to care for this part of the task, and also to care for the patients outside after their removal is accomplished.

Because the personnel would be busy as outlined above, it appeared that other trained persons were needed to take care of the second part of the task. The remainder of the hospital attaches furnishes a few trained hands, but not nearly enough, as it takes two or more men to remove one patient. The general public can not be counted upon because they might not collect in time, and even if they did, they would not be trained in the work. The Detroit Fire Department, noted for its efficient work of all kinds, appreciated the difficulty of meeting the exacting requirements and cooperates splendidly by installing a regular street fire alarm box with its own individual number, inside the main hospital building, near the front entrance. From this box anyone on the first floor, including the patients in the convalescent ward, can turn in a city alarm. By making special arrangements, Rescue Squad No. 1, located at the fire station nearest the hospital, and also Rescue Squad No. 2, located near the business district, will both respond to every alarm coming from this special city alarm box.

When a city alarm is turned in from this box it brings not only the fire apparatus, but also 20 men trained in removing helpless persons and gives an adequate force.

These two groups of workers with a clearly defined division of labor

Many hospitals face more serious fire hazards in the winter than in other seasons, so this paper describing fire prevention and safety measures of one institution will serve to remind others to look into this subject before cold weather sets in. In this connection it is interesting to note that more than 3,200 inspections of hospitals for fire hazards have been made as a result of the activity of the A. H. A. committee on fire insurance.



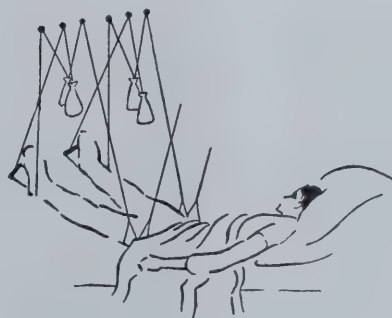
"This escape is especially designed to take the hospital mattress, patient and all, and deliver to ground level without jar or danger."

constitutes one of the most perfect set-ups for fire rescue work employed by any hospital.

President P. W. A. Fitzsimmons and Surgical Director H. N. Torrey are justly proud of the perfection of these life saving provisions which are now on the same high plane of excellence, as are all other features of this model hospital where perfection is ever secured, namely, by treating minor details with the same painstaking care and precise treatment that all big or important matters receive in all well managed industries or institutions.

Group Seeks to Help Disabled

The National Rehabilitation Association, devoted to the promotion of vocational restoration of the disabled, determined, at its 1932 convention in Chicago to carry on an extensive campaign to place the need for the restoration of the handicapped before the country. "It is better," said one speaker, "to spend five or even ten thousand dollars to rehabilitate a single case of a worker of twenty-one, than to carry him throughout life as a dependent." Current information indicates that



fully 7,000,000 people are handicapped in their earning capacity by accident or disease which prevents them from engaging in any occupation, or which makes a change of vocation imperative. Crippled children, injured workmen, the blind and deaf, the victims of tuberculosis and heart disease, need special training for work they can do, and special help to obtain employment.

The National Rehabilitation Association aims to secure the cooperation of all agencies—local, state and national—which are engaged in work for the handicapped; and to unite their efforts in a campaign of publicity and education of the general public on the needs and opportunities in this field.

The Association selected as director John A. Lapp of Chicago, formerly president of the National Conference of Social Work, and one of the men most responsible for the promotion of the vocational education system under the Smith-Hughes Act. Dr. Lapp's long experience in the promotion of social welfare and social legislation and in giving expression to the ideals of social justice, will now be given to the country in this program of social justice for the millions of disabled people who, without aid and assistance to regain their power to support themselves, must fall into dependency.

Officers of the National Rehabilitation Association are: president, Oscar M. Sullivan, director of re-education, State of Minnesota; vice-president, H. D. Hicker, Sacramento, Calif.; secretary, Homer W. Nichols, Frankfort, Ky.; treasurer, LeRoy N. Koonz, Augusta, Me. The executive committee of the Association is composed of the officers and William F. Faulkes, Madison, Wis.; Marlow B. Perrin, Columbus, O.; H. L. Stanton, Raleigh, N. C.; Willis W. Grant, Des Moines, Ia.; E. P. McGraw, Cheyenne, Wyo.; M. M. Walter, Harrisburg, Pa. Temporary offices of the Association are at 537 South Dearborn Street, Chicago.

OKLAHOMA MEETING

Hospital executives of Oklahoma will hold their annual meeting in Tulsa November 29 and 30. An interesting program is being prepared and a cordial invitation is extended to all hospital people in the state. Officers in charge of the meeting are Dr. T. M. Aderhold, El Reno Sanitarium, El Reno, president; R. L. Loy, Jr., Oklahoma City General Hospital, vice-president; Dr. A. J. Weedn, Duncan, secretary; executive committee: J. H. Rucks, Wesley Hospital, Oklahoma City; Dr. F. P. Von Keller, Von Keller Hospital, Ardmore; Dr. W. H. Livermore, Chickasha Hospital, Chickasha; Dr. V. C. Tisdal, Tisdal Hospital, Elk City.

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and hospital administrators should encourage the College to see that the facts set forth in the 1932 report and the position announced by the College should be upheld and maintained and that in future years more attention paid to the character of administration of hospitals seeking approval or wishing to remain on the approved list.

Carried to its logical conclusion, this step taken by the College this year should lead to a set of standards for hospital administration, for how else can the College determine the character of the management of a hospital? It is to be remembered that the Hospital Standardization movement did not begin as such. The reason why the standardization program was launched was that the College, which had set out to improve the practice of surgery, found that it had to go a step behind this and improve conditions in the hospital in order to make good surgery possible.

In order to encourage good hospital administration and to provide a basis upon which good management may be recognized, therefore it would seem that the College or some other organization now must do something about training superintendents or at least about setting up standards by which the ability of a superintendent may be determined.

If the College carries out this logical program, it again will be carrying on work that is far removed from the practice of surgery and an activity that many believe is wholly within the province of some other association or group. This is not said in criticism of the College, however, for had not the College itself done the things that it found necessary to do for the good of the patient and for the advancement of surgery and of hospital service, then it is likely that these things either would not have been done or they would not have been done as well as the College has done them.

In this connection it is noteworthy to remark that the College has never turned back when the ramifications of the Hospital Standardization movement led it into new fields or activities, no matter how difficult and how expensive these new programs appeared to be. Therefore, it is reasonable to suppose that the College will not turn back in this new activity dealing with greater recognition by itself and by hospital trustees of the value of a competent superintendent.

It also must be remembered that as each new ramification extended the contacts and field of influence of the College, it automatically tended to limit and decrease the influence of other groups. In following up this first step toward the recognition of experience and ability in hospital administration, therefore, the influence and power of the College will be further developed.

College of Surgeons Recognizes Superintendents

Recognition by the American College of Surgeons in its 1932 report on Hospital Standardization of the fact that experience and competency in hospital administration are a factor in the well-managed hospital should be received with gratification by every one who is interested in raising standards of administration. This statement by the College, which is reprinted with comments in this issue, should be shown to every board of trustees of every hospital which has fully or partially met the standards of the College or whose board may wish to have their institution placed on the approved list.

As a matter of fact, of course, at present this recognition in itself does not mean much, but it is a beginning

These Things Affect Every Hospital

One of the greatest assets to individual hospitals and to local and state associations is the wisdom and experience of the American Hospital Association. Annually the best minds in the great group of progressive hospital people of the United States and Canada are directed not only to current problems and difficulties, but also to efforts to look into the future and to see what lies ahead for the field.

A future program for the American Hospital Association was presented at the Detroit session, thanks to the thoughtfulness of the president, Paul Fesler, and to his choice of the man to peer into the future, Dr. Goldwater. Incidentally it might be offered as further proof

of the fact that even hospital history repeats itself to mention that Dr. Goldwater was given a similar commission 26 years ago. But Dr. Goldwater's program for the development and expansion of the A. H. A. is not visionary, nor impractical. It is based on long experience in hospital administration, in association affairs, and widespread contact with hospitals, and there is every reason to believe that the program can be carried out to the material advantage of the field.

But in the end, who or what is to benefit by such a program? The association and its members, as such, of course, but no less effectively, all the progressive hospitals. For the problems and plans relating to the future which the A. H. A. report mentioned and for which it offered various suggestions are not abstract, intangible things, of only academic value and importance. The things spoken of affect every hospital and every hospital executive directly.

Every hospital and every hospital executive, therefore, should consider the things which the A. H. A. suggests as important and necessary to do. Moreover, every hospital and every hospital executive should join in the effort to do these things. In the case of local and state associations, many practical opportunities are offered for carrying out phases of this future program, to the advantage of each and every hospital in the area of the group.

An idea how the suggestions of the A. H. A. can be carried out by a local or state group is shown in the program for the Chicago Hospital Association that now is under consideration. This same program is possible of accomplishment by a number of other local and state groups. Action is necessary, of course. As Mr. Lutes says, "Realization of our power is one thing; use of it is another."

Exhibitors' Association Begins Second Decade

In "This Month, 15 and 10 Years Ago," in the October issue, *HOSPITAL MANAGEMENT* noted that ten years ago the Hospital Exhibitors' Association was organized. In its first decade this association has done some fine things for the hospital associations and for its members. Through splendid leadership and vision it has immensely improved certain features of the annual expositions and it has worked with the various groups to make these annual shows of greater value to visitors.

The promotion of better relations between hospital people and those who serve the sick by providing equipment and supplies and authentic information concerning their use and maintenance, and thus help executives to serve patients better, more speedily and more economically, was one of the most valuable contributions of the Hospital Exhibitors' Association.

Just as among the membership of the hospital associations, there is a vast amount of experience and information, so among the membership of the H. E. A. there is experience and knowledge that would be invaluable to many hospitals. An experienced hospital executive realizes what his or her experience means, and can appreciate the difficulties that are the lot of the inexperienced newcomer; so, too, does experience count in the use of materials, equipment and supplies. Sometimes, however, an inexperienced executive will not realize just how great help the suggestions of a manufacturer or salesman may be, and fail to seek this help.

The experience of manufacturers and other members of the H. E. A. is likewise at the disposal of committees

of the A. H. A., especially those dealing with equipment and supplies in a more detailed and technical way. It would seem good policy on the part of such committees to utilize to a greater degree this advice and cooperation. As a matter of fact, in some instances in the past inexperienced committeemen have taken technical problems involving features of manufacture, design, etc., outside the field and have brought in reports that indicated lack of familiarity with the subject. Such reports do not do credit to a committee.

With ten years of successful accomplishment behind it, the Hospital Exhibitors' Association now enters its second decade better equipped than ever to cooperate with and to help individuals and hospital as well as association committees and the field as a whole.

Milwaukee in September; Chicago in October, 1933

It is unfortunate that the American Hospital Association and the American College of Surgeons are to meet in 1933 with about a month's interval between, but the fact that they will meet in Milwaukee and in Chicago may help a number to be present at both conventions, which might not be the case had the cities been so widely separated as Detroit and St. Louis.

These conventions are the most profitable and practical "courses" or "institutes" available to many executives and it would seem desirable that they might be arranged so that attendance at both might be possible to more hospital people.

This is not said in criticism of either group, for only those directly charged with the arrangements and numerous details of a convention can know how many special conditions must be met in the selection of a convention city and a convention date.

But if either or both were to change announced plans for 1933, this change would not be regarded as a confession of weakness or as admission of inferiority, but it would be universally hailed as an evidence of the desire of those making the change to do even more to help as many hospital executives as possible.

Praise for Good Work Pays Full Dividends

Experienced superintendents are putting into practice a certain and simple way of improving morale and of getting best efforts from department heads. This was demonstrated a few days ago. A visitor who knew that a certain department head was discouraged and disheartened, happened to be in the office of the superintendent of a hospital when the department head came in to get a decision on an important departmental matter. After giving his views, the superintendent praised the work of the department executive, saying that not only he, but some members of the board and of the staff were appreciative of her splendid service and that they, too, wanted the department head to know of it. It is safe to assume that the few words of praise and encouragement definitely increased the good will of that executive and her activity, with the result that for some time afterward this department head and her associates carried on most enthusiastically and efficiently. Had not the words been spoken, the feeling of discouragement might have prevailed and affected all in the department. It pays to encourage a worker.

Practical, Helpful Forum Feature of A. C. S. Conference

THE 1932 hospital conference of the American College of Surgeons at St. Louis last month was featured by the most interesting and profitable forum on administrative problems in many years, and, according to some veteran administrators, it was by far superior to any similar forum that they could recall. This forum was held in the spacious gymnasium of the nurses' home of Jewish Hospital, with visitors seated in a semi-circular arrangement, and with the equipment being demonstrated and the demonstrators in the center of the horseshoe.

While a great deal of the value of the forum was due to the excellent and practical way in which those participating presented their subjects and then answered the questions which followed, and also to the informality and good fellowship which is characteristic of a round table conducted by Robert Jolly, Memorial Hospital, Houston, Tex., who was in charge, yet equal credit must be given to the management of the Jewish Hospital and to Miss E. Muriel Anscombe, superintendent, who so capably planned the details of the different demonstrations.

Miss Anscombe and Dr. M. T. MacEachern, who arranged the entire program of the hospital conference, aided Mr. Jolly in the unusual forum. Those who participated by introducing the topics or by assisting in the demonstrations included: Jerome Simon, M. D., resident, St. Louis City Hospital No. 1; Clara Coleman, R. N., superintendent of nurses, St. Louis City Hospital No. 1; Max Myer, M. D., director of surgery, Marie Dowler, R. N., surgical supervisor; Llewellyn Sale, M. D., president, medical staff; Bethel Curry, B. S., head dietitian; Florence King, and Edna E. Peterson, R. N., principal, school of nursing, all of Jewish Hospital.

At one time a count showed 304 people gathered around the speaker or demonstrator, and each brief, pertinent introductory talk was followed by an explanation of technique or detail, in which the equipment, such as a fully loaded food conveyor, etc., was used. In each instance it was necessary to curtail the number of questions in order that the next section of the forum might be begun.

Another excellent forum was conducted in the auditorium of St.

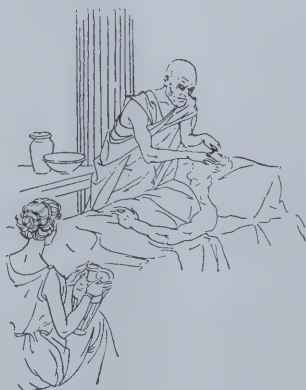
Mary's Hospital nurses' home, with another good attendance.

The popular round tables indicated that financial and economic problems and questions of a similar nature were of special interest to the visitors. A great deal of time was taken up with comments on hospital insurance schemes and proposed plans and much interest was expressed in the Houston, Tex., plan which was described by Mr. Jolly in the last issue.

Another feature of the conference was the contact that was made on behalf of the hospitals and medical profession by representatives of the College. The extent of this contact, with the public through radio, talks in schools, before clubs, etc., was graphically proved by the fact that a throng, estimated at 10,000, stormed the hall where the public health meeting was to be given. This necessitated the hasty use of another hall, and after this was filled literally thousands were turned away.

The registration of hospital executives was considerably below normal, undoubtedly due to the fact that the conference followed that of the A. H. A. by so long an interval and in so distant a city from Detroit. But those who went to St. Louis were unanimous in their praise of the program and of the benefit they derived from the round tables. The attendance of fellows of the College and the size of the exposition of equipment and supplies was much nearer normal than the hospital conference registration.

The program of the hospital con-



ference, as outlined in the last issue, was followed with very few changes, and the vast majority of the papers touched on current problems and were presented by men and women who knew whereof they spoke.

From the standpoint of hospital administrators, the big feature of the annual congress of the College is the announcement of the approved list of hospitals. This list is published elsewhere in this issue.

The 1933 conference of the College is to be held in Chicago beginning October 8, which is nearly a month later than the convention of the American Hospital Association in Milwaukee, which begins September 11.

Ontario Aids Hold Conference

The Ontario Hospital Aids Association, an association of hospital auxiliaries throughout the province, held a most successful convention at Sarnia October 5-6. Dr. Helen MacMurchy, chief of the division of child welfare, department of national health, spoke on maternal welfare, and the Hon. W. S. Martin, minister of public welfare, addressed the annual banquet. F. D. Reville, president, General Hospital, Brantford, expressed greetings of the Ontario Hospital Association of which he was 1931-32 president. New officers of the Aids Association include:

President, Mrs. Oliver W. Rhynas, Burlington; recording secretary, Mrs. Frederick C. Bodley, Hamilton; corresponding secretary, Miss Mary Colter, Brantford; treasurer, Mrs. G. W. Houston, Hamilton; advisory committee—convener, Mrs. Stuart Watt, St. Catharines; Miss Agnes Climie, Hamilton; Mrs. G. W. Wood, St. Catharines; Mrs. J. A. McLean, Chatham; Miss Grace Wright, Mount Forest; Mrs. George Gliottoni, Toronto; executive—presidents of affiliated aids.

Mrs. Rhynas was made the official representative to the Ontario Hospital Association and also given a certificate of life membership.

A delightful tea was given at the Sarnia Hospital, when Miss Lee, superintendent, and Miss Paterson were hostesses.

95 PER CENT FULL

The annual report of Montreal General Hospital for the year 1931 shows that the central division had an occupancy of 94.87 per cent and the western division of 95.4 per cent, an average for the whole hospital of 94.96.

College of Surgeons Approves 2,094 Hospitals Fully, 200 Conditionally, of 3,464 Surveyed

ALABAMA

ANNISTON, Garner Hospital.
 BESSEMER, Bessemer General Hospital.
 BIRMINGHAM
 Birmingham Baptist Hospital.
 Children's Hospital.
 Hillman Hospital.
 Norwood Hospital.
 St. Vincent's Hospital.
 South Highlands Infirmary.
 DECATUR, Benevolent Society Hospital.
 DOTHAN
 Frasier-Ellis Hospital.
 Moody Hospital.
 FAIRFIELD, Employees' Hospital of the Tennessee Coal, Iron and Railroad Company.
 GADSDEN, Holy Name of Jesus Hospital.
 JASPER, Walker County Hospital.

MOBILE

City Hospital.
 Mobile Infirmary.
 Providence Infirmary.
 United States Marine Hospital.
 MONTGOMERY, St. Margaret's Hospital.

SELMA

Goldsby King Memorial Hospital.
 Vaughan Memorial Hospital.

SYLACAUGA

Drummond-Fraser Hospital.
 Sylacauga Infirmary.
 TUSCALOOSA, Veterans' Administration Hospital.

TUSKEGEE, Veterans' Administration Hospital.
 TUSKEGEE INSTITUTE, John A. Andrew Memorial Hospital.

ARIZONA

BISBEE, Copper Queen Hospital.
 GANADO, Sage Memorial Hospital.
 GLOBE, Gila County Hospital.
 JEROME, United Verde Copper Company Hospital.
 MIAMI, Miami-Inspiration Hospital.
 PHOENIX
 Good Samaritan Hospital.
 St. Joseph's Hospital.
 PRESCOTT, Mercy Hospital.
 TUCSON
 St. Mary's Hospital and Sanatorium.
 Southern Methodist Hospital and Sanatorium.
 Southern Pacific Sanatorium.
 Veterans' Administration Hospital.
 WHIPPLE BARRACKS, Veterans' Administration Hospital.

ARKANSAS

EL DORADO
 (c) Henry C. Rosamond Memorial Hospital.
 Warner Brown Hospital.
 FAYETTEVILLE, Fayetteville City Hospital.
 FORT SMITH
 St. Edward's Mercy Hospital.
 St. John's Hospital.
 Sparks Memorial Hospital.
 HOPE, Josephine Hospital.
 HOT SPRINGS
 (c) Army and Navy General Hospital.
 Leo N. Levi Memorial Hospital.
 St. Joseph's Hospital.
 JONESBORO, St. Bernard's Hospital.
 LITTLE ROCK
 (c) Arkansas Children's Hospital.
 Baptist State Hospital.
 Little Rock City Hospital.
 Missouri Pacific Hospital.
 St. Vincent's Infirmary.
 NORTH LITTLE ROCK, Veterans' Administration Hospital.
 RUSSELLVILLE, (c) St. Mary's Hospital.
 TEXARKANA
 Michael Meagher Memorial Hospital.
 St. Louis Southwestern Hospital.

CALIFORNIA

ALAMEDA, (c) Alameda Sanatorium on the South Shore.
 ALHAMBRA, Alhambra Hospital.
 ARLINGTON, Riverside County Hospital.
 BAKERSFIELD, Mercy Hospital.
 BERKELEY
 Alta Bates Hospital.
 Ernest V. Cowell Memorial Hospital, University of California.
 BURBANK, Burbank Hospital.

COMPTON, Compton Sanitarium and Las Campanas Hospital.
 EAST OAKLAND, East Oakland Hospital.
 FORT BRAGG, Redwood Coast Hospital.
 FRENCH CAMP, (c) San Joaquin General Hospital.

FRESNO

General Hospital of Fresno County.
 St. Agnes Hospital.

GLENDALE

Glendale Sanitarium and Hospital.
 Physicians and Surgeons Hospital.

LA JOLLA, Scripps Memorial Hospital.

LIVERMORE

Arroyo Sanitarium.
 Veterans' Administration Hospital.
 LOMA LINDA, Loma Linda Sanitarium and Hospital.

LONG BEACH

Harriman Jones Clinic and Hospital.
 Long Beach Community Hospital.
 Seaside Hospital.

LOS ANGELES

(c) Angelus Hospital.
 California Hospital.
 Cedars of Lebanon Hospital.
 Children's Hospital.
 French Hospital.
 Golden State Hospital.

Hollywood Clara Barton Memorial Hospital.
 Hospital of the Good Samaritan.

Methodist Hospital of Southern California.
 Orthopedic Hospital.

Queen of the Angels Hospital.
 St. Vincent's Hospital.
 Santa Fe Coast Lines Hospital.

Veterans' Administration Hospital.
 White Memorial Hospital.

MARE ISLAND, United States Naval Hospital.

MONTEREY, Monterey Hospital.

MONTEREY PARK, Garfield Hospital.

NATIONAL CITY, Paradise Valley Sanitarium and Hospital.

OAKLAND

Children's Hospital of the East Bay.
 Fabiola Hospital.
 Highland Hospital of Alameda County.

Peralta Hospital.
 Providence Hospital.

Samuel Merritt Hospital.

ORANGE

Orange County General Hospital.
 St. Joseph Hospital.

ORNDORF, St. John's Hospital.

PALO ALTO, Veterans' Administration Hospital.

PASADENA, Pasadena Hospital.

POMONA, Pomona Valley Community Hospital.

RIVERSIDE, Riverside Community Hospital.

ROSS, Ross General Hospital.

SACRAMENTO

Mater Misericordiae Hospital.
 Sacramento Hospital.
 Sutter Hospital.

SAN BERNARDINO

St. Bernardine's Hospital.
 San Bernardino County Charity Hospital.

SAN DIEGO

Mercy Hospital.
 San Diego County General Hospital.
 United States Naval Hospital.

SAN FERNANDO, Veterans' Administration Hospital.

SAN FRANCISCO

Franklin Hospital.
 French Hospital.
 Hospital for Children.
 Letterman General Hospital.
 Mary's Help Hospital.
 Mount Zion Hospital.
 St. Francis Hospital.
 St. Joseph's Hospital.
 St. Luke's Hospital.
 St. Mary's Hospital.
 San Francisco Hospital.
 Shriners' Hospital for Crippled Children.

Southern Pacific General Hospital.

Stanford University Hospitals.

United States Marine Hospital.

University of California Hospitals.

SANITARIUM, St. Helena Sanitarium and Hospital.

SAN JOSE

O'Connor Sanitarium.
 San Jose Hospital.
 Santa Clara County Hospital.

SAN LEANDRO, Fairmont Hospital of Alameda County.

SAN MATEO

Community Hospital of San Mateo County.
 Mills Memorial Hospital.

SAN PEDRO

San Pedro General Hospital.
 United States Naval Hospital Ship Relief.

SANTA ANA, (c) Santa Ana Valley Hospital.
 Santa Barbara

St. Francis Hospital of Santa Barbara.
 Santa Barbara Cottage Hospital.
 Santa Barbara General Hospital.

SANTA MONICA, Santa Monica Hospital.
 STOCKTON, St. Joseph's Home and Hospital.

TORRANCE, Jared Sidney Torrance Memorial Hospital.
 VENTURA, E. P. Foster Memorial Hospital.

VETERANS HOME, Veterans Home of California.
 WESTWOOD, (c) Westwood Hospital.

WOODLAND, Woodland Clinic Hospital.

COLORADO

BOULDER

Boulder-Colorado Sanitarium.
 Community Hospital.

COLORADO SPRINGS

Beth-El General Hospital.
 Cragmor Sanatorium.
 Glockner Sanatorium and Hospital.
 National Methodist Episcopal Sanatorium for Tuberculosis.
 St. Francis Hospital.

DENVER

Agnes Memorial Sanatorium.
 Beth Israel Hospital.
 Children's Hospital.
 Denver General Hospital.
 Fitzsimons General Hospital.
 Mercy Hospital.
 National Jewish Hospital.
 Porter Sanitarium and Hospital.
 Presbyterian Hospital of Colorado.
 St. Anthony's Hospital.
 St. Joseph's Hospital.
 St. Luke's Hospital.

Sanatorium of the Jewish Consumptives' Relief Society.

University of Colorado Hospitals:
 Colorado General Hospital.
 Colorado Psychopathic Hospital.

DURANGO, Mercy Hospital.

FORT LYON, Veterans' Administration Hospital.

GRAND JUNCTION, St. Mary's Hospital.

GREELEY, Greeley Hospital.

LA JUNTA

Atchison, Topeka and Santa Fe Railroad Hospital.

(c) Mennonite Hospital and Sanitarium.

LONGMONT, Longmont Hospital.

PUEBLO

Corwin Hospital of the Colorado Fuel and Iron Company.
 Parkview Hospital.
 St. Mary Hospital.

SALIDA

Denver and Rio Grande Western Hospital Association's Hospital.
 (c) Red Cross Hospital.

STERLING, St. Benedict Hospital.

TRINIDAD, Mt. San Rafael Hospital.

CONNECTICUT

BRIDGEPORT

Bridgeport Hospital.
 St. Vincent's Hospital.

BRISTOL, Bristol Hospital.

DANBURY, Danbury Hospital.

DERBY, Griffin Hospital.

GREENWICH, Greenwich Hospital.

HARTFORD

Hartford Hospital.
 Mount Sinai Hospital.

Municipal Hospital.

St. Francis Hospital.

MERIDEN, Meriden Hospital.

MIDDLETOWN, Middlesex Hospital.

NEW BRITAIN, New Britain General Hospital.

NEW HAVEN

Grace Hospital.
 Hospital of St. Raphael.

New Haven Hospital.

NEWINGTON, Veterans' Administration Hospital.

NEW LONDON

Home Memorial Hospital.
 Lawrence and Memorial Associated Hospitals.

NORWALK, Norwalk General Hospital.

NORWICH, William W. Backus Hospital.

PUTNAM, (c) Day Kimball Hospital.

SOUTH MANCHESTER, Manchester Memorial Hospital.

STAMFORD, Stamford Hospital.

TORRINGTON, Charlotte Hungerford Hospital.

WATERBURY

St. Mary's Hospital.

Waterbury Hospital.

WILLIMANTIC, St. Joseph's Hospital.

WINSTED, (c) Litchfield County Hospital.

DELAWARE

FARNHURST, Delaware State Hospital.

LEWES, Beebe Hospital of Lewes.

WILMINGTON

Delaware Hospital.
 Homeopathic Hospital.

St. Francis Hospital.

Wilmington General Hospital.

DISTRICT OF COLUMBIA

WASHINGTON

Central Dispensary and Emergency Hospital.
 Children's Hospital of the District of Columbia.

Columbia Hospital for Women and Lying-in Asylum.
 Episcopal Eye, Ear, and Throat Hospital.

Freedmen's Hospital.

Gallinger Municipal Hospital.

Garfield Memorial Hospital.

Georgetown University Hospital.

George Washington University Hospital.

National Homeopathic Hospital.

Providence Hospital.

St. Elizabeth's Hospital.

Sibley Memorial Hospital.

United States Naval Hospital.

Veterans' Administration Hospital.

Here is the list of hospitals approved by the American College of Surgeons as of October 1, 1932. The mark (c) indicates conditional approval. A number of hospitals on this list have tentative approval only, subject to correcting certain conditions on or before January, 1933. As mentioned elsewhere in this issue, an immature superintendent in some instances has been the cause of the withholding of approval temporarily.

Walter Reed General Hospital.
Washington Sanitarium and Hospital.

FLORIDA

CENTURY, Turberville Hospital.
CLEARWATER, Morton F. Plant Endowed Hospital.
DAYTONA BEACH, Halifax District Hospital.
FORT LAUDERDALE, (c)Memorial Hospital.
GAINESVILLE
Alachua County Hospital.
University of Florida Infirmary.
JACKSONVILLE
Brewster Hospital.
Duval County Hospital.
Riverside Hospital.
St. Luke's Hospital.
St. Vincent's Hospital.
KEY WEST, United States Marine Hospital.
LAKE CITY, Veterans' Administration Hospital.
LAKELAND, Morrell Memorial Hospital.
MIAMI
Dade County Hospital.
James M. Jackson Memorial Hospital.
Victoria Hospital.
MIAMI BEACH, St. Francis Hospital.
OCALA, Munroe Memorial Hospital.
ORLANDO
(c)Orange General Hospital.
(c)Orlando-Florida Sanitarium and Hospital.
PENSACOLA
Pensacola Hospital.
United States Naval Hospital.
ST. AUGUSTINE
East Coast Hospital.
Flagler Hospital.
ST. PETERSBURG
City Hospitals
(Mound Park—Mercy).
St. Anthony's Hospital.
TALLAHASSEE, (c)Florida Agricultural and Mechanical College Hospital.
TAMPA
Children's Hospital of Tampa.
Tampa Municipal Hospital.
WEST PALM BEACH, Good Samaritan Hospital.

GEORGIA

ALBANY, Phoebe Putney Memorial Hospital.
ATHENS, Athens General Hospital.
ATLANTA
Crawford W. Long Memorial Hospital.
Georgia Baptist Hospital.
Grady Memorial Hospital.
Henrietta Eggleston Hospital for Children.
Piedmont Hospital.
St. Joseph's Infirmary.
United States Penitentiary Hospital.
Veterans' Administration Hospital.
Wesley Memorial Hospital.
AUGUSTA
University Hospital.
Veterans' Administration Hospital.
Wilberforce Hospital for Women and Children.
CANTON, (c)Coker's Hospital.
COLUMBUS, City Hospital.
CUTHBERT, Patterson Hospital.
DECATUR, Scottish Rite Hospital for Crippled Children.
GAINESVILLE, Downey Hospital.
MACON
Macon Hospital.
Middle Georgia Sanatorium.
MILLEN, Millen Hospital.
PLAINS, Wise Sanitarium.
ROME
Harbin Hospital.
McCall Hospital.
SAVANNAH
Central of Georgia Railway Hospital.
United States Marine Hospital.
THOMASVILLE, John D. Archbold Memorial Hospital.
WAYCROSS
Atlantic Coast Lines Hospital.
(c)Ware County Hospital.

IDAHO

BOISE
St. Alphonsus Hospital.
St. Luke's Hospital.
Veterans' Administration Hospital.
IDAHO FALLS, Idaho Falls Latter Day Saints Hospital.
LEWISTON, St. Joseph's Hospital.
NAMPA, Mercy Hospital.
POCATELLO
Pocatello General Hospital.
St. Anthony's Mercy Hospital.
WALLACE, Providence Hospital.

ILLINOIS

ALTON, St. Joseph's Hospital.
AURORA
Copley Hospital.
St. Joseph Mercy Hospital.
BERWYN, Berwyn Hospital.
BLUE ISLAND, St. Francis Hospital.
CAIRO, St. Mary's Infirmary.
CHAMPAIGN, (c)Burnham City Hospital.
CHICAGO
Albert Merritt Billings Hospital.
Alexian Brothers Hospital.
American Hospital.
Augustana Hospital.
Bethany Sanitarium and Hospital.
Chicago Eye, Ear, Nose, and Throat Hospital.
Chicago Lying-in Hospital and Dispensary.
Chicago Memorial Hospital.
Children's Memorial Hospital.
Columbus Hospital.
Cook County Hospital.
Edgewater Hospital.
Englewood Hospital.
Evangelical Deaconess Hospital.
Evangelical Hospital of Chicago.
Frances E. Willard National Temperance Hospital.
Garfield Park Hospital.
Grant Hospital.
Henrotin Hospital.
Holy Cross Hospital.
Hospital of St. Anthony de Padua.
Illinois Central Hospital.
Illinois Eye and Ear Infirmary.
Illinois Masonic Hospital.
Jackson Park Hospital.
John B. Murphy Hospital.
Lake View Hospital.
Lewis Memorial Maternity Hospital.
Lutheran Deaconess Home and Hospital.
Lutheran Memorial Hospital.
(c)Martha Washington Hospital.
Mercy Hospital.
Michael Reese Hospital.
Misericordia Hospital and Home for Infants.
Mother Cabrini Memorial Hospital.
Mount Sinai Hospital.
Municipal Contagious Disease Hospital.
Municipal Tuberculosis Sanitarium.
Passavant Memorial Hospital.
Post-Graduate Hospital.
Presbyterian Hospital.
(c)Provident Hospital.
Ravenswood Hospital.
Research and Educational Hospitals of the State of Illinois.
Roseland Community Hospital.
St. Anne's Hospital.
St. Bernard's Hospital.
St. Elizabeth's Hospital.
St. Joseph's Hospital.
St. Luke's Hospital.
St. Mary of Nazareth Hospital.
Shriners' Hospital for Crippled Children.
South Chicago Community Hospital.
South Shore Hospital.
Swedish Covenant Hospital.
United States Marine Hospital.
University Hospital of Chicago.
Washington Boulevard Hospital.
Wesley Memorial Hospital.
(c)West Side Hospital.
Women and Children's Hospital.
DANVILLE
Lake View Hospital.
St. Elizabeth's Hospital.
Veterans' Administration Hospital.
DECATUR
Decatur and Macon County Hospital.
Wabash Employees' Hospital.
DE KALB, De Kalb Public Hospital.
DIXON, Dixon Public Hospital.
DWIGHT, Veterans' Administration Hospital.
EAST ST. LOUIS
Christian Welfare Hospital.
St. Mary's Hospital.
ELGIN, Sherman Hospital.
EVANSTON
Evanston Hospital.
St. Francis Hospital.
EVERGREEN PARK, Little Company of Mary Hospital.
FREEPORT
(c)Evangelical Deaconess Hospital.
(c)St. Francis Hospital.
GALESBURG, Galesburg Cottage Hospital.
GENEVA, Community Hospital.
GRANITE CITY, St. Elizabeth's Hospital.
GREAT LAKES, United States Naval Hospital.
HARVEY, Ingalls Memorial Hospital.
HIGHLAND PARK, Highland Park Hospital.
HINES, Veterans' Administration Hospital.
HINSDALE, Hinsdale Sanitarium and Hospital.

JACKSONVILLE
Our Savior's Hospital.
Passavant Memorial Hospital.
JOLIET
St. Joseph's Hospital.
Silver Cross Hospital.
KANKAKEE, St. Mary Hospital.
KEWANEE
Kewanee Public Hospital.
St. Francis Hospital.
MELROSE PARK, Westlake Hospital.
MOLINE
Lutheran Hospital.
Moline Public Hospital.
MONMOUTH, Monmouth Hospital.
MURPHYSBORO, St. Andrew's Hospital.
NORTH CHICAGO, Veterans' Administration Hospital.
OAK PARK
Oak Park Hospital.
West Suburban Hospital.
OLNEY, Olney Sanitarium.
OTTAWA, John Stewart Ryburn Memorial Hospital.
PANA, (c)Huber Memorial Hospital.
PEORIA, (c)St. Francis Hospital.
QUINCY
Blessing Hospital.
St. Mary's Hospital.
ROCKFORD
Rockford Hospital.
St. Anthony's Hospital.
Swedish-American Hospital.
ROCK ISLAND, St. Anthony's Hospital.
SPRINGFIELD, Palmer Tuberculosis Sanatorium.
STERLING, Public Hospital of the City of Sterling.
WAUKEGAN
St. Therese's Hospital.
Victory Memorial Hospital.

INDIANA

ANDERSON, St. John's Hospital.
CROWN POINT, Lake County Tuberculosis Sanatorium.
EAST CHICAGO, St. Catherine's Hospital.
EVANSVILLE
Protestant Deaconess Hospital.
St. Mary's Hospital.
United States Marine Hospital.
Walker Hospital.
FORT WAYNE
(c)Fort Wayne Lutheran Hospital.
(c)Methodist Episcopal Hospital.
St. Joseph's Hospital.
FRANKFORT, Clinton County Hospital.
GARY
Illinois Steel Company, Gary Hospital.
Methodist Hospital.
St. Mary's Mercy Hospital.
HAMMOND, St. Margaret's Hospital.
INDIANAPOLIS
Indianapolis City Hospital.
Indiana University Hospitals—
Robert W. Long Hospital.
James Whitcomb Riley Hospital for Children.
William H. Coleman Hospital for Women.
Methodist Episcopal Hospital.
(c)St. Francis Hospital.
St. Vincent's Hospital.
Veterans' Administration Hospital.
JEFFERSONVILLE, Clark County Memorial Hospital.
LA FAYETTE
La Fayette Home Hospital.
St. Elizabeth's Hospital.
MARION
(c)Grant County Hospital.
Veterans' Administration Hospital.
MICHIGAN CITY
Clinic Hospital.
St. Anthony's Hospital.
MISHAWAKA, St. Joseph's Hospital.
MUNCIE, Ball Memorial Hospital.
NEW ALBANY, St. Edward's Hospital.
PRINCETON, Methodist Episcopal Hospital.
RICHMOND, Reid Memorial Hospital.
SOUTH BEND
Epworth Hospital.
St. Joseph Hospital.
SULLIVAN, Mary Sherman Hospital.
TERRE HAUTE
St. Anthony's Hospital.
Union Hospital.

IOWA

AMES, Iowa State College Hospital.
ANAMOSA, (c)Mercy Hospital.
BURLINGTON
Burlington Hospital.
Mercy Hospital.
CARROLL, (c)St. Anthony Hospital.
CEDAR RAPIDS
Mercy Hospital.
St. Luke's Methodist Hospital.
CENTERTVILLE, St. Joseph's Hospital.
CLINTON
Jane Lamb Memorial Hospital.
St. Joseph Mercy Hospital.

COUNCIL BLUFFS
Jennie Edmundson Memorial Hospital.
Mercy Hospital.
DAVENPORT
Mercy Hospital.
St. Luke's Hospital.
DES MOINES
Iowa Lutheran Hospital and Iowa Lutheran Maternity Hospital.
Iowa Methodist Hospital.
Mercy Hospital.
Polk County Public Hospitals—
Broadlawn Division.
(c)General Division.
DUBUQUE, Finley Hospital.
FORT DODGE, St. Joseph's Mercy Hospital.
FORT MADISON, (c)Atchison, Topeka, and Santa Fe Hospital.
GRINNELL, Community Hospital.
HAMPTON, Lutheran Hospital.
IOWA CITY
Mercy Hospital.
State University of Iowa, University Hospitals.
KEOKUK
Graham Protestant Hospital.
St. Joseph's Hospital.
KNOXVILLE, Veterans' Administration Hospital.
LE MAR, Sacred Heart Hospital.
MASON CITY
Park Hospital.
St. Joseph's Mercy Hospital.
NEW HAMPTON, St. Joseph's Hospital.
OTTUMWA
(c)Ottumwa Hospital.
St. Joseph's Hospital.
Sunnyslope Sanatorium.
SIOUX CITY
Lutheran Hospital.
Methodist Hospital.
St. Joseph's Mercy Hospital.
St. Vincent's Hospital.
WASHINGTON, Washington County Hospital.
WATERLOO
Allen Memorial Hospital.
St. Francis Hospital.
WAVERLY, St. Joseph Mercy Hospital.

KANSAS

ARKANSAS CITY, (c)Mercy Hospital.
BELOIT, Community Hospital.
CONCORDIA, St. Joseph's Hospital.
DODGE CITY, St. Anthony's Hospital.
ET. DORADO, Susan B. Allen Memorial Hospital.
ELLSWORTH, Ellsworth Hospital.
FORT LEAVENWORTH, United States Penitentiary Annex Hospital.
FORT SCOTT, Mercy Hospital.
GARDEN CITY, (c)St. Catherine's Hospital.
GREAT BEND, St. Rose Hospital.
HALSTEAD, Halstead Hospital.
HAYS
Hays Protestant Hospital.
St. Anthony's Hospital.
HUTCHINSON
Grace Hospital.
St. Elizabeth's Mercy Hospital.
INDEPENDENCE, (c)Mercy Hospital.
KANSAS CITY
Bell Memorial Hospital.
Bethany Methodist Hospital.
Providence Hospital.
St. Margaret's Hospital.
LEAVENWORTH
St. John's Hospital.
United States Penitentiary Hospital.
Veterans' Administration Hospital.
LIBERAL, Epworth Hospital.
MULVANE, Atchison, Topeka, and Santa Fe Hospital.
NEWTON
Axtell Christian Hospital.
Bethel Deaconess Hospital.
PARSONS, Missouri-Kansas-Texas Railroad Employees' Hospital.
PITTSBURG, Mt. Carmel Hospital.
SABETHA, St. Anthony Murdock Memorial Hospital.
SALINA, St. John's Hospital.
TOPEKA
Atchison, Topeka, and Santa Fe Hospital.
Christ's Hospital.
Jane C. Stormont Hospital.
St. Francis Hospital.
WELLINGTON, Hatcher Hospital.
WICHITA
St. Francis Hospital.
Wesley Hospital.
Wichita Hospital.
WINFIELD
St. Mary's Hospital.
William Newton Memorial Hospital.

KENTUCKY

BEREA, Berea College Hospital.
BOWLING GREEN, (c)City Hospital.
COVINGTON, St. Elizabeth's Hospital.
DAYTON, (c)Speers Memorial Hospital.

GLASGOW, Community Hospital.
JENKINS, Jenkins Hospital.
LEXINGTON
Good Samaritan Hospital.
St. Joseph's Hospital.
Shriners' Hospital for Crippled Children—Mobile Unit.
Veterans' Administration Hospital.
LOUISVILLE
Children's Free Hospital.
Jewish Hospital.
J. N. Norton Memorial Infirmary.
Kentucky Baptist Hospital.
Kosair Crippled Children Hospital.
Louisville City Hospital.
Methodist Episcopal Deaconess Hospital.
St. Anthony's Hospital.
St. Joseph's Infirmary.
Sts. Mary and Elizabeth Hospital.
United States Marine Hospital.
LYNCH, Lynch Hospital of the United States Coal and Coke Company.
MURRAY, William Mason Memorial Hospital.
OUTWOOD, Veterans' Administration Hospital.
PADUCAH
Illinois Central Hospital.
Riverside Hospital.
PARIS, W. W. Massie Memorial Hospital.
PIKEVILLE, (c) Methodist Hospital of Kentucky.

LOUISIANA

ALEXANDRIA
Baptist Hospital.
Veterans' Administration Hospital.
BATON ROUGE
(c) Baton Rouge General Hospital.
Our Lady of the Lake Hospital.
BOGALUSA, Elizabeth Sullivan Memorial Hospital.
CARVILLE, United States Marine Hospital.
HAYNESVILLE, Haynesville Hospital.
JACKSON, Parker Hospital of the East Louisiana Hospital for Insane.
LAKE CHARLES, St. Patrick's Sanatorium.
MONROE
St. Francis Sanitarium.
(c) Vaughan-Wright-Bendel Clinic Hospital.
NEW ORLEANS
Eye, Ear, Nose, and Throat Hospital.
Flint-Goodridge Hospital of Dillard University.
French Hospital.
Hotel Dieu.
Illinois Central Hospital.
Mercy Hospital—Soniat Memorial.
Southern Baptist Hospital.
State of Louisiana Charity Hospital.
Touro Infirmary.
United States Marine Hospital.
PINEVILLE, Fuqua Memorial Hospital of the Central Louisiana State Hospital for the Insane.
SHREVEPORT
Highland Sanitarium.
North Louisiana Sanitarium.
Shreveport Charity Hospital.
Shreveport Sanitarium and T. E. Schumpert Memorial Hospital.
Shriners' Hospital for Crippled Children.
Tri-State Hospital.

MAINE

AUGUSTA
Augusta General Hospital.
Veterans' Administration Hospital.
BANGOR, Eastern Maine General Hospital.
BATH, Bath City Hospital.
BELFAST, Waldo County General Hospital.
FARMINGTON, Franklin County Memorial Hospital.
GARDINER, Gardiner General Hospital.
LEWISTON
Central Maine General Hospital.
St. Mary's General Hospital.
PORTLAND
Children's Hospital.
Maine Eye and Ear Infirmary.
Maine General Hospital.
St. Barnabas Hospital.
State Street Hospital.
United States Marine Hospital.
PRESQUE ISLE, (c) Presque Isle General Hospital.
RUMFORD, Rumford Community Hospital.
SANFORD, Henrietta D. Goodall Hospital.
WATERVILLE
Sisters' Hospital.
Thayer Hospital.

MARYLAND

ANNAPOLIS, United States Naval Hospital.

BALTIMORE
Baltimore City Hospitals.
Bon Secours Hospital.
Children's Hospital.
Church Home and Infirmary.
Franklin Square Hospital.
Hospital for the Women of Maryland.
Howard A. Kelly Hospital.
Johns Hopkins Hospital.
Maryland General Hospital.
Mercy Hospital.
Provident Hospital and Free Dispensary.
St. Agnes Hospital.
St. Joseph's Hospital.
Sinai Hospital.
South Baltimore General Hospital.
Union Memorial Hospital.
United States Marine Hospital.
University Hospital of the University of Maryland.
Volunteers of America Hospital.
West Baltimore General Hospital.
CAMBRIDGE, Cambridge-Maryland Hospital.
CUMBERLAND
Alleghany Hospital of the Sisters of Charity.
Memorial Hospital.
EASTON, Emergency Hospital.
FREDERICK, Frederick City Hospital.
HAGERSTOWN, Washington County Hospital.
HILLSDALE, James Lawrence Kernan Hospital and Industrial School of Maryland for Crippled Children.
PERRY POINT, Veterans' Administration Hospital.
SALISBURY, Peninsula General Hospital.

MASSACHUSETTS

ADAMS, W. B. Plunkett Memorial Hospital.
AMESBURY, Amesbury Hospital.
ARLINGTON, Symmes Arlington Hospital.
ATTLEBORO, Sturdy Memorial Hospital.
AYER, (c) Community Memorial Hospital.
BEDFORD, Veterans' Administration Hospital.
BEVERLY, Beverly Hospital.
BOSTON
Beth Israel Hospital.
Boston City Hospital.
Boston Floating Hospital.
Boston Lying-in Hospital.
Carney Hospital.
Children's and Infants' Hospital.
Collis P. Huntington Memorial Hospital.
Emerson Hospital.
Evangeline Booth Maternity Hospital and Home.
Faulkner Hospital.
Harley Private Hospital.
Hart Private Hospital.
House of the Good Samaritan.
Long Island Hospital.
Massachusetts Eye and Ear Infirmary.
Massachusetts General Hospital.
Massachusetts Memorial Hospitals.
Massachusetts Women's Hospital.
New England Baptist Hospital.
New England Deaconess Hospital.
New England Hospital for Women and Children.
Peter Bent Brigham Hospital.
Robert Breck Brigham Hospital.
St. Elizabeth's Hospital.
St. Margaret's and St. Mary's Lying-in Hospitals.
Salvation Army Roxbury Hospital and Clinic.
BROCKTON
Brockton Hospital.
Goddard Hospital.
BROOKLINE
Brooks Hospital.
Free Hospital for Women.
CAMBRIDGE
Cambridge City Hospital.
Cambridge Hospital.
CHELSEA
Captain John Adams Hospital of Soldiers' Home in Massachusetts.
Chelsea Memorial Hospital.
United States Marine Hospital.
United States Naval Hospital.
CLINTON, Clinton Hospital.
CONCORD, Emerson Hospital in Concord.
EVERETT, Whidden Memorial Hospital.
FALL RIVER
Fall River General Hospital.
St. Anne's Hospital.
Truesdale Hospital.
Union Hospital in Fall River.
FITCHBURG, Burbank Hospital.
FRAMINGHAM, Framingham-Union Hospital.
GARDNER, Henry Heywood Memorial Hospital.
GLOUCESTER, Addison Gilbert Hospital.

GREENFIELD, Franklin County Public Hospital.
HAVERHILL, Municipal Hospitals.
HOLDEN, Holden District Hospital.
HOLYOKE
Holyoke Hospital.
Providence Hospital.
LAWRENCE, Lawrence General Hospital.
LEOMINSTER, Leominster Hospital.
LOWELL
Lowell General Hospital.
St. John's Hospital.
St. Joseph's Hospital.
LYNN, Lynn Hospital.
MALDEN, Malden Hospital.
MEDFORD, Lawrence Memorial Hospital.
MELROSE
Melrose Hospital.
New England Sanitarium and Hospital.
MIDDLEBOROUGH, Lakeville State Sanatorium.
MILFORD, (c) Milford Hospital.
MILTON, Milton Hospital and Convalescent Home.
MONTAGUE CITY, Farren Memorial Hospital.
NATICK, Leonard Morse Hospital.
NEW BEDFORD, St. Luke's Hospital.
NEWBURYPORT
Anna Jaques Hospital.
Newburyport Homeopathic Hospital.
NEWTON LOWER FALLS, Newton Hospital.
NORTH ADAMS, North Adams Hospital.
NORTHAMPTON
Cooley Dickinson Hospital.
Veterans' Administration Hospital.
NORTH WILMINGTON, North Reading State Sanatorium.
NORWOOD, Norwood Hospital.
PALMER, Wing Memorial Hospital.
PEABODY, Josiah B. Thomas Hospital.
PITTSFIELD
House of Mercy Hospital.
St. Luke's Hospital.
QUINCY, Quincy City Hospital.
RUTLAND
Rutland State Sanatorium.
Veterans' Administration Hospital.
SALEM
North Shore Babies' Hospital.
Salem Hospital.
SOMERVILLE, Somerville Hospital.
SOUTHBRIDGE, (c) Harrington Memorial Hospital.
SOUTH WEYMOUTH, (c) Weymouth Hospital.
SPRINGFIELD
(c) Health Department Hospital.
Mercy Hospital.
Shriners' Hospital for Crippled Children.
Springfield Hospital.
Wesson Maternity Hospital.
Wesson Memorial Hospital.
TAUNTON, Morton Hospital.
VINEYARD HAVEN, United States Marine Hospital.
WALTHAM, Waltham Hospital.
WARE, Mary Lane Hospital.
WESTFIELD
Noble Hospital.
Westfield State Sanatorium.
WINCHESTER, Winchester Hospital.
WOBURN, Charles Choate Memorial Hospital.
WORCESTER
City Hospital.
Fairlawn Hospital.
Memorial Hospital.
St. Vincent Hospital.
Worcester Hahnemann Hospital.
WRENTHAM, Pondville Hospital at Norfolk.

MICHIGAN

ALBION, James W. Sheldon Memorial Hospital.
ANN ARBOR
St. Joseph's Mercy Hospital.
University Hospital.
BATTLE CREEK
Battle Creek Sanitarium.
Leila Y. Post Montgomery Hospital.
Nichols Memorial Hospital.
BAY CITY, Mercy Hospital.
BENTON HARBOR, Mercy Hospital.
CADILLAC, Mercy Hospital.
CALUMET, (c) Calumet and Hecla Mining Company Hospital.
CAMP CUSTER, Veterans' Administration Hospital.
DETROIT
Charles Godwin Jennings Hospital.
Children's Hospital of Michigan.
(c) Delray General Hospital.
(c) Detroit Eye, Ear, Nose, and Throat Hospital.
(c) Dunbar Memorial Hospital.
(c) East Side General Hospital.
Evangelical Deaconess Hospital.
(c) Florence Crittenton Hospital and Home.
Grace Hospital.

Harper Hospital.
Henry Ford Hospital.
Herman Kiefer Hospital.
Jefferson Clinic and Diagnostic Hospital.
(c) Lincoln Hospital.
Michigan Mutual Hospital.
Providence Hospital.
Receiving Hospital.
St. Joseph's Mercy Hospital.
St. Mary's Hospital.
United States Marine Hospital.
Woman's Hospital.
ELOISE, Eloise Infirmary.
FLINT
Hurley Hospital.
Women's Hospital.
GOODRICH, Goodrich General Hospital.
GRAND RAPIDS
Blodgett Memorial Hospital.
Butterworth Hospital.
St. Mary's Hospital.
GROSSE POINTE, Cottage Hospital of Grosse Pointe.
HAMTRAMCK, (c) St. Francis Hospital.
HANCOCK, St. Joseph's Hospital.
HIGHLAND PARK, Highland Park General Hospital.
IRONWOOD, Grand View Hospital.
ISHPEMING, Ishpeming Hospital.
JACKSON
Mercy Hospital.
W. A. Foote Memorial Hospital.
KALAMAZOO
Borgess Hospital.
Bronson Methodist Hospital.
LANSING
Edward W. Sparrow Hospital.
St. Lawrence Hospital.
MARQUETTE, (c) St. Luke's Hospital.
MONROE, (c) Mercy Hospital.
MT. CLEMENS, St. Joseph Sanitarium and Hospital.
MUSKEGON
Hackley Hospital.
Mercy Hospital.
Muskegon County Sanatorium.
NILES, (c) Pawating Hospital.
OWOSSO, Memorial Hospital.
PONTIAC
Pontiac General Hospital.
St. Joseph Mercy Hospital.
SAGINAW
Saginaw County Contagious Hospital.
Saginaw General Hospital.
St. Luke's Hospital.
St. Mary's Hospital.
St. Johns, Clinton Memorial Hospital.
SAULT STE. MARIE, Chippewa County War Memorial Hospital.
THREE RIVERS, (c) Three Rivers Hospital.
WYANDOTTE, Wyandotte General Hospital.

MINNESOTA

ALBERT LEA, (c) Naeve Hospital.
ALEXANDER, (c) Douglas County Hospital.
BRAINEED, St. Joseph's Hospital.
CROOKSTON
(c) Bethesda Hospital.
St. Vincent's Hospital.
DULUTH
St. Luke's Hospital.
St. Mary's Hospital.
EVELETH, More Hospital.
FERGUS FALLS
(c) George B. Wright Memorial Hospital.
St. Luke's Hospital.
GRACEVILLE, Western Minnesota Hospital.
HIBBING
(c) Adams Hospital.
Rood Hospital.
LITTLE FALLS, St. Gabriel's Hospital.
MANKATO
Immanuel Hospital.
St. Joseph's Hospital.
MINNEAPOLIS
Abbott Hospital.
Asbury Hospital.
Eitel Hospital.
Fairview Hospital.
Hill Crest Surgical Hospital.
Lutheran Deaconess Home and Hospital.
Maternity Hospital.
Minneapolis General Hospital.
Northwestern Hospital.
St. Andrew's Hospital.
St. Barnabas Hospital.
St. Mary's Hospital.
Shriners' Hospital for Crippled Children.
Swedish Hospital.
University Hospital.
Veterans' Administration Hospital.
NOPENING, Nopening Sanatorium.
OAK TERRACE, Glen Lake Sanatorium.
RED WING, St. John's Hospital.
ROCHESTER
Colonial Hospital.
Kahler Hospital.

Can a 30-Bed Hospital Be Approved?

AT hospital conferences of the American College of Surgeons and at other meetings the statement frequently is made that even small hospitals can meet the requirements for approval.

These statements were recalled with the publication of the 1932 approved list, and a study of the list was made with a view of discovering how many hospitals of less than 30 beds received recognition.

It was found that a total of 26 institutions of less than 30 beds won a place on the 1932 approved list. The College did not summarize bed capaci-

ties other than in groups of 100 beds and over, 50 beds and over, and 25 beds and over, but this summary indicated that special conditions handicapping the meeting of requirements increase as the size of the hospital diminishes. For instance, 93.9 per cent of hospitals of 100 beds or over that were surveyed were approved fully and conditionally, but this percentage dropped to 81.4 in the case of hospitals of 50 beds or over, and to 66.2 for hospitals of 25 beds and over.

In the case of hospitals of from 25 to 49 beds the total number fully and conditionally approved was 20.5 per cent of the number surveyed.

The 29 hospitals of less than 30 beds that were approved this year were divided as follows as to type of ownership or control:

Privately owned 13, fraternal 2, community 5, industrial 3, federal 1, city 1, university 1. Thus 20 of the 26 hospitals may be said to have had a type of control, that is, a relationship between owner or board and management and staff, different from the ordinary community hospital.

In point of size, these hospitals of less than 30 beds were divided as follows: 29 beds, 2; 28 beds, 7; 27 beds, 5; 26 beds, 2; 25 beds, 10.

St. Mary's Hospital.
Worrell Hospital.
ST. CLOUD
St. Cloud Hospital.
Veterans' Administration Hospital.
ST. PAUL
Ancker Hospital.
Bethesda Hospital.
Charles T. Miller Hospital.
Children's Hospital.
Gillette State Hospital for Crippled Children.
Midway Hospital.
Mounds Park Sanitarium.
Northern Pacific Beneficial Association Hospital.
St. John's Hospital.
St. Joseph's Hospital.
St. Luke's Hospital.
(c) St. Paul Hospital.
STILLWATER, Lakeview Memorial Hospital.
THIEF RIVER FALLS, St. Luke's Hospital.
WADENA, (c) Wesley Hospital.
WARREN, Warren Hospital.
WILLMAR, Willmar Hospital.
WINONA, Winona General Hospital.

MISSISSIPPI

BILOXI, Biloxi Hospital.
BROOKHAVEN, (c) King's Daughters' Hospital.
CENTREVILLE, (c) Field Memorial Hospital.
COLUMBIA, Columbia Clinic Hospital.
CORINTH, McRae Hospital.
ELECTRIC MILLS, George C. Hixon Memorial Hospital.
GREENVILLE, King's Daughters' Hospital (White).
GULFPORT
King's Daughters' Hospital.
Veterans' Administration Hospital.
HATTIESBURG, South Mississippi Infirmary.
HOUSTON, Houston Hospital.
JACKSON
Jackson Infirmary.
Mississippi Baptist Hospital.
MERIDIAN
(c) Anderson Infirmary.
(c) Matty Hersee Hospital.
Meridian Sanitarium.
Rush's Infirmary.
NATCHEZ
(c) Chamberlain-Rice Hospital.
Natchez Charity Hospital.
Natchez Sanatorium.
OXFORD, (c) Oxford Hospital.
SANATORIUM, Mississippi State Tuberculosis Sanatorium.
STATE COLLEGE, James Z. George Memorial Hospital.
TUPELO, Tupelo Hospital.
VICKSBURG
Vicksburg Hospital.
Vicksburg Infirmary.
Vicksburg Sanitarium and Crawford Street Hospital.
WINONA, Winona Infirmary.
BOONVILLE, St. Joseph's Hospital.
CAPE GIRARDEAU
St. Francis Hospital.
Southeast Missouri Hospital.

MISSOURI

CARTHAGE, McCune-Brooks Hospital.
CLAYTON, St. Louis County Hospital.
COLUMBIA
Boone County Hospital.
University Hospitals, University of Missouri.
EXCELSIOR SPRINGS, Veterans' Administration Hospital.
HANNIBAL
(c) Levering Hospital.
St. Elizabeth's Hospital.
INDEPENDENCE, Independence Sanitarium.
JEFFERSON BARRACKS, Veterans' Administration Hospital.
JEFFERSON CITY
Missouri State Prison Hospital.
St. Mary's Hospital.
JOPLIN
Freeman Hospital.
St. John's Hospital.
KANSAS CITY
Children's Mercy Hospital.
Kansas City General Hospital.
Kansas City General Hospital (Colored Division).
Menorah Hospital.
Research Hospital.
St. Joseph Hospital.
St. Luke's Hospital.
St. Mary's Hospital.
Trinity Lutheran Hospital.
Veterans' Administration Hospital.
Wheatley-Provident Hospital.
LOUISIANA, (c) Pike County Hospital.
MARYVILLE, St. Francis Hospital.
MOBERLY, Wabash Employees' Hospital.
ST. CHARLES, St. Joseph's Hospital.
ST. JOSEPH
Missouri Methodist Hospital.
St. Joseph's Hospital.
ST. LOUIS
Alexian Brothers Hospital.
Barnard Free Skin and Cancer Hospital.
Barnes Hospital.
Bethesda Hospital.
Christian Hospital.
City Sanitarium.
De Paul Hospital.
Evangelical Deaconess Home and Hospital.
Frisco Employes' Hospital.
Isolation Hospital.
Jewish Hospital of St. Louis.
Lutheran Hospital.
Missouri Baptist Hospital.
Missouri Pacific Hospital.
Mount St. Rose Sanatorium.
Robert Koch Hospital.
St. Anthony's Hospital.
St. John's Hospital.
St. Louis Children's Hospital.
St. Louis City Hospital.
(c) St. Louis City Hospital No. 2.
St. Louis Maternity Hospital.
St. Luke's Hospital.
St. Mary's Hospital.
St. Mary's Infirmary.
Shriner's Hospital for Crippled Children.
United States Marine Hospital.

SPRINGFIELD
Burge Hospital.
St. John's Hospital.
Springfield Baptist Hospital.

MONTANA

ANACONDA, St. Ann's Hospital.
BILLINGS
(c) Billings Deaconess Hospital.
St. Vincent's Hospital.
BOZEMAN, (c) Bozeman Deaconess Hospital.
BUTTE
Murray Hospital.
St. James Hospital.
FORT HARRISON, Veterans' Administration Hospital.
GLENDALE, Northern Pacific Beneficial Association Hospital.
GREAT FALLS
Columbus Hospital.
Montana Deaconess Hospital.
HAYRE
Kennedy Deaconess Hospital.
Sacred Heart Hospital.
HELENA
St. John's Hospital.
St. Peter's Hospital.
KALISPELL, Kalispell General Hospital.
LEWISTOWN, St. Joseph's Hospital.
MILES CITY, Holy Rosary Hospital.
MISSOULA
Northern Pacific Beneficial Association Hospital.
St. Patrick's Hospital.
Thornton Hospital.

NEBRASKA

ALLIANCE, St. Joseph's Hospital.
BEATRICE, Lutheran Hospital.
COLUMBUS, St. Mary's Hospital.
FALLS CITY, Falls City Hospital.
GRAND ISLAND, St. Francis Hospital.
LINCOLN
Bryan Memorial Hospital.
Lincoln General Hospital.
St. Elizabeth's Hospital.
Veterans' Administration Hospital.
McCook, (c) St. Catherine of Sienna Hospital.
OMAHA
Bishop Clarkson Memorial Hospital.
Creighton Memorial, St. Joseph's Hospital.
Douglas County Hospital.
Evangelical Covenant Hospital.
Immanuel Hospital.
Nebraska Methodist Episcopal Hospital.
St. Catherine's Hospital.
University of Nebraska Hospital.
SCOTTSBLUFF, (c) West Nebraska Methodist Episcopal Hospital.

NEVADA

EAST ELY, Steptoe Valley Hospital.
ELKO, Elko General Hospital.
RENO, St. Mary's Hospital.

NEW HAMPSHIRE

BERLIN, Hospital St. Louis.
CLAREMONT, Claremont General Hospital.

CONCORD
Margaret Pillsbury General Hospital.
New Hampshire Memorial Hospital.
DOVER, Wentworth Hospital.
EXETER, (c) Exeter Hospital.
GRASMERE, Hillsborough County General Hospital.
HANOVER, Mary Hitchcock Memorial Hospital.
KEENE, Elliot Community Hospital.
LACONIA, Laconia Hospital.
MANCHESTER
Balch Hospital.
Elliot Hospital.
L'Hopital De Notre Dame De Lourdes.
Sacred Heart Hospital.
NASHUA
Nashua Memorial Hospital.
St. Joseph Hospital.
PORTSMOUTH
Portsmouth Hospital.
United States Naval Hospital.

NEW JERSEY

ATLANTIC CITY, Atlantic City Hospital.
BAYONNE, Bayonne Hospital and Dispensary.
BRIDGETON, Bridgeton Hospital.
CAMDEN
Cooper Hospital.
West Jersey Homeopathic Hospital.
EAST ORANGE, Homeopathic Hospital of Essex County.
ELIZABETH
Alexian Brothers Hospital.
Elizabeth General Hospital and Dispensary.
St. Elizabeth Hospital.
ENGLEWOOD, Englewood Hospital.
FRANKLIN, (c) Franklin Hospital.
HACKENSACK, Hackensack Hospital.
HOBOKEN, St. Mary's Hospital.
IRVINGTON, Irvington General Hospital.
JERSEY CITY
Christ Hospital.
Jersey City Hospital.
Margaret Hague Maternity Hospital.
St. Francis Hospital.
KEARNY, West Hudson Hospital.
LONG BRANCH, Monmouth Memorial Hospital.
LYONS, Veterans' Administration Hospital.
MONTCLAIR
Montclair Community Hospital.
Mountainside Hospital.
St. Vincent's Hospital.
MORRISTOWN
All Souls Hospital.
Morristown Memorial Hospital.
MOUNT HOLLY, Burlington County Hospital.
NEPTUNE, Raleigh Fitkin-Paul Morgan Memorial Hospital.
NEWARK
Babies' Hospital.
Hospital and Home for Crippled children.
Hospital for Women and Children.
Hospital of St. Barnabas.
Newark Beth Israel Hospital.
Newark City Hospital.
Newark Eye and Ear Infirmary.

Newark Memorial Hospital.
Presbyterian Hospital.
St. James Hospital.
St. Michael's Hospital.
NEW BRUNSWICK
Middlesex General Hospital.
St. Peter's General Hospital.
ORANGE
New Jersey Orthopedic Hospital and Dispensary.
Orange Memorial Hospital.
St. Mary's Hospital.
PASSAIC
Passaic General Hospital.
St. Mary's Hospital.
PATERSON
Nathan and Miriam Barnert Memorial Hospital.
Paterson General Hospital.
St. Joseph's Hospital.
PERTH AMBOY, Perth Amboy City Hospital.
PLAINFIELD, Muhlenberg Hospital.
PRINCETON, Princeton Hospital.
RAHWAY, Rahway Memorial Hospital.
RIDGEWOOD, Bergen County Hospital.
SECAUCUS, Hudson County Hospital.
SOMERVILLE, Somerset Hospital.
SUMMIT, Overlook Hospital.
TEANECK, Holy Name Hospital.
TRENTON
Mercer Hospital.
New Jersey State Hospital.
St. Francis Hospital.
(c) Trenton Municipal Colony Hospitals.
William McKinley Memorial Hospital.
VERONA, Essex Mountain Sanatorium.
VINELAND, Newcomb Hospital.
WEEHAWKEN, (c) North Hudson Hospital.

NEW MEXICO

ALBUQUERQUE
Atchison, Topeka and Santa Fe Hospital.
St. Joseph Sanatorium and Hospital.
Veterans Administration Hospital.
CLOVIS, (c) Atchison, Topeka, and Santa Fe Hospital.
FORT BAYARD, Veterans' Administration Hospital.
FORT STANTON, United States Marine Hospital.
GALLUP, St. Mary's Hospital.
RATON, (c) New Mexico Miners' Hospital.
ROSWELL, St. Mary's Hospital.
SANTA FE, St. Vincent Hospital and Sanatorium.

NEW YORK

ALBANY
Albany Hospital.
Anthony N. Brady Maternity Home.
(c) Child's Hospital.
Memorial Hospital.
St. Peter's Hospital.
AMSTERDAM
Amsterdam City Hospital.
St. Mary's Hospital.
AUBURN, Auburn City Hospital.
BATAVIA
(c) Batavia Hospital.
St. Jerome's Hospital.
BATH, Veterans' Administration Hospital.
BAY SHORE, Southside Hospital.
BINGHAMTON, Binghamton City Hospital.
BRONX, Veterans' Administration Hospital.
BRONXVILLE, Lawrence Hospital.
BROOKLYN
Bay Ridge Sanitarium.
Beth-El Hospital.
Beth Moses Hospital.
Brooklyn Eye and Ear Hospital.
Brooklyn Hospital.
Bushwick Hospital.
Caledonian Hospital of the City of New York.
Carson C. Peck Memorial Hospital.
Coney Island Hospital.
Cumberland Hospital.
Greenpoint Hospital.
Hospital of the Holy Family.
House of St. Giles the Cripple.
Israel-Zion Hospital.
Jewish Hospital of Brooklyn.
Kings County Hospital.
Kingston Avenue Hospital.
Long Island College Hospital.
Lutheran Hospital.
Methodist Episcopal Hospital.
Norwegian Lutheran Deaconesses' Home and Hospital.
Prospect Heights Hospital and Brooklyn Maternity.
St. Catherine's Hospital.
St. John's Hospital.
St. Mary's Hospital of the City of Brooklyn.
St. Peter's Hospital.
Wyckoff Heights Hospital of Brooklyn.
BUFFALO
Buffalo City Hospital.
Buffalo Columbus Hospital.
Buffalo General Hospital.
Buffalo Hospital of the Sisters of Charity.
Children's Hospital of Buffalo.
Deaconess Hospital.
Emergency Hospital of the Sisters of Charity.
Memorial Hospital of Buffalo.
Mercy Hospital.
Millard Fillmore Hospital.
St. Mary's Maternity Hospital.
United States Marine Hospital.
CAMBRIDGE, Mary McClellan Hospital.
CANANDAIGUA
Frederick Ferris Thompson Hospital.
Veterans' Administration Hospital.
CASTLE POINT, Veterans' Administration Hospital.
CLIFTON SPRINGS, Clifton Springs Sanitarium and Clinic.
COHOES, Cohoes Hospital.
COOPERSTOWN, Mary Imogene Bassett Hospital.
CORNING, (c) Corning Hospital.
CORNWALL, Cornwall Hospital.
CORTLAND, Cortland County Hospital.
DOBBS FERRY, Dobbs Ferry Hospital.
ELLIS ISLAND, United States Marine Hospital.
ELMIRA
Arnot-Ogden Memorial Hospital.
St. Joseph's Hospital.
ENDICOTT, Ideal Hospital of Endicott.
FAR ROCKAWAY, St. Joseph's Hospital.
FLUSHING, Flushing Hospital and Dispensary.
GENEVA, Geneva General Hospital.
GLEN COVE, North Country Community Hospital.
GLENS FALLS, Glens Falls Hospital.
GLOVERSVILLE, Nathan Littauer Hospital.
HORNELL
Bethesda Hospital.
St. James Mercy Hospital.
HUDSON, Hudson City Hospital.
ITHACA, Tompkins County Memorial Hospital.
JAMAICA
Mary Immaculate Hospital.
Queensboro Hospital.
JAMESTOWN
Jamestown General Hospital.
Woman's Christian Association Hospital.
JOHNSON CITY, Charles S. Wilson Memorial Hospital.
KINGSTON
Benedictine Hospital.
Kingston Hospital.
LACKAWANNA
Moses Taylor Hospital.
Our Lady of Victory Hospital.
LONG ISLAND CITY, St. John's Long Island City Hospital.
MALONE, Alice Hyde Memorial Hospital.
MIDDLETOWN, Elizabeth A. Horton Memorial Hospital.
MINEOLA, Nassau Hospital.
MT. KISCO, Northern Westchester Hospital.
MOUNT VERNON, Mount Vernon Hospital.
NEWBURGH, St. Luke's Hospital of Newburgh, N. Y.
NEW DORP BEACH, S. I., St. John's Guild Seaside Hospital.
NEW ROCHELLE, New Rochelle Hospital.
NEW YORK CITY
Babies Hospital of the City of New York.
Beekman Street Hospital.
Bellevue Hospital.
Beth David Hospital.
Beth Israel Hospital Medical Center.
Booth Memorial Hospital.
(c) Broad Street Hospital.
Bronx Hospital.
Central Neurological Hospital.
Columbus Hospital.
Columbus Hospital Extension.
Community Hospital.
Fifth Avenue Hospital.
Fordham Hospital.
French Benevolent Society Hospital.
Gouverneur Hospital.
Harlem Hospital.
Herman Knapp Memorial Eye Hospital.
Hospital for Joint Diseases.
Hospital for the Ruptured and Crippled.
Hospital of the Rockefeller Institute for Medical Research.
Jewish Memorial Hospital.
Knickerbocker Hospital.
Lebanon Hospital.
Lenox Hill Hospital.

Lincoln Hospital.
Lutheran Hospital of Manhattan.
Manhattan Eye, Ear, and Throat Hospital.
Memorial Hospital for the Treatment of Cancer and Allied Diseases.
Metropolitan Hospital.
Midtown Hospital.
Misericordia Hospital.
Montefiore Hospital.
Morrisania Hospital.
Mount Sinai Hospital.
Neurological Institute of New York.
New York City Cancer Institute Hospital.
New York City Hospital.
New York Eye and Ear Infirmary.
New York Foundling Hospital.
New York Homeopathic Medical College and Flower Hospital.
New York Hospital.
New York Infirmary for Women and Children.
New York Nursery and Child's Hospital.
New York Orthopedic Dispensary and Hospital.
New York Polyclinic Medical School and Hospital.
New York Post-Graduate Medical School and Hospital.
Park East Hospital.
Park West Hospital.
(c) Peoples Hospital.
Presbyterian Hospital in the City of New York.
Riverside Hospital.
Roosevelt Hospital.
St. Elizabeth's Hospital.
St. Francis' Hospital.
St. Luke's Hospital.
St. Mary's Hospital for Children.
St. Vincent's Hospital of the City of New York.
Sloane Hospital for Women.
Stuyvesant Square Hospital.
Sydenham Hospital.
United States Naval Hospital.
West Side Hospital and Dispensary.
Willard Parker Hospital.
Woman's Hospital in the State of New York.
NIAGARA FALLS
Mt. St. Mary's Hospital.
Niagara Falls Memorial Hospital.
NORTHPORT, L. I., Veterans' Administration Hospital.
NORWICH, Chenango Memorial Hospital.
OLEAN, Olcan General Hospital.
ONEIDA, Broad Street Hospital.
ONEONTA, Aurelia Osborn Fox Memorial Hospital.
OSSINGING-ON-HUDSON
Ossining Hospital.
Sing Sing Prison Hospital.
OSWEGO, (c) Oswego Hospital.
OTISVILLE, Municipal Sanatorium.
PENN YAN, Soldiers and Sailors Memorial Hospital.
PLATTSBURGH
Champlain Valley Hospital.
Physicians' Hospital of Plattsburgh.
PORT CHESTER, United Hospital.
POUGHKEEPSIE
St. Francis Hospital.
Vassar Brothers Hospital.
RICHMOND HILL, Jamaica Hospital.
ROCHESTER
Genesee Hospital.
Highland Hospital.
(c) Monroe County Hospital.
Park Avenue Hospital.
Rochester General Hospital.
Rochester Municipal Hospital.
St. Mary's Hospital.
Strong Memorial Hospital.
ROCKAWAY BEACH, Rockaway Beach Hospital.
ROME, Rome Hospital and Murphy Memorial Hospital.
SARATOGA SPRINGS, Saratoga Hospital.
SCHENECTADY, Ellis Hospital.
SOUTHAMPTON, Southampton Hospital.
STAPLETON, S. I., United States Marine Hospital.
SUNMOUNT, Veterans' Administration Hospital.
SYRACUSE
Crouse-Ingving Hospital.
General Hospital of Syracuse.
St. Joseph Hospital.
Syracuse Memorial Hospital.
University Hospital of the Good Shepherd.
TARRYTOWN, Tarrytown Hospital.
TRONDEROGA, Moses-Ludington Hospital.
TOMPKINSVILLE, S. I., Staten Island Hospital.
TROY
Leonard Hospital.
Samaritan Hospital.
Troy Hospital.

UTICA
Faxon Hospital.
Masonic Soldiers and Sailors Memorial Hospital.
St. Elizabeth's Hospital.
St. Luke's Home and Hospital.
Utica General Hospital.
Utica Memorial Hospital.
VALHALLA, Grasslands Hospital.
WARSAW, Wyoming County Community Hospital.
WATERTOWN
House of the Good Samaritan.
Mercy Hospital.
WAVERLY, Tioga County General Hospital.
WEST HAVERSTRAW, New York State Reconstruction Home.
WEST NEW BRIGHTON, S. I.
St. Vincent's Hospital.
Sea View Hospital.
WHITE PLAINS, White Plains Hospital.
YONKERS
St. John's Riverside Hospital.
St. Joseph's Hospital.
Yonkers General Hospital.

NORTH CAROLINA

ASHEVILLE
Asheville Mission Hospital.
(c) Aston Park Hospital.
BILTMORE, Biltmore Hospital.
CHARLOTTE
Charlotte Eye, Ear, and Throat Hospital.
Mercy Hospital.
New Charlotte Sanatorium.
Presbyterian Hospital.
St. Peter's Hospital.
DURHAM
Duke Hospital.
Lincoln Hospital.
Watts Hospital.
FAYETTEVILLE
Highsmith Hospital.
(c) Pittman Hospital.
GASTONIA
(c) City Hospital.
North Carolina Orthopedic Hospital.
GOLDSBORO, (c) Goldsboro Hospital.
GREENSBORO
L. Richardson Memorial Hospital.
St. Leo's Hospital.
Sternberger Children's Hospital.
GREENVILLE, (c) Pitt Community Hospital.
HENDERSON, Maria Parham Hospital.
HICKORY, Richard Baker Hospital.
HIGH POINT, High Point Hospital.
KINSTON
Memorial General Hospital.
(c) Parrott Memorial Hospital.
LEAKSVILLE, (c) Leaksville Hospital.
LENOIR, Caldwell Hospital.
LINCOLNTON, Lincoln Hospital.
LUMBERTON
(c) Baker Sanatorium.
(c) Thompson Memorial Hospital.
MT. AIRY, Martin Memorial Hospital.
NORTH WILKESBORO, (c) Wilkes Hospital.
OTEEN, Veterans' Administration Hospital.
PINEHURST, Moore County Hospital.
RALEIGH
Rex Hospital.
St. Agnes Hospital.
ROCKY MOUNT
Atlantic Coast Line Railroad Hospital.
Park View Hospital.
RUTHERFORDTON, Rutherford Hospital.
SALISBURY, (c) Rowan General Hospital.
SHELBY, Shelby Hospital.
STATESVILLE
Davis Hospital.
Long's Sanatorium.
TARBORO, Edgecombe General Hospital.
TRYON, (c) St. Luke's Hospital.
WASHINGTON, Tayloe Hospital.
WAYNESVILLE, (c) Haywood County Hospital.
WILMINGTON
Bulluck Hospital.
James Walker Memorial Hospital.
WILSON, Moore-Herring Hospital.
WINSTON-SALEM
City Memorial Hospital.
North Carolina Baptist Hospital.
WRIGHTSVILLE SOUND, (c) Babies' Hospital.

NORTH DAKOTA

BISMARCK
Bismarck Hospital and Deaconess Home.
St. Alexius Hospital.
DEVILS LAKE, Mercy Hospital.
DICKINSON, St. Joseph's Hospital.
FARGO
St. John's Hospital.
St. Luke's Hospital.
Veterans' Administration Hospital.

GRAFTON, (c) Grafton Deaconess Hospital.
 GRAND FORKS
 Grand Forks Deaconess Hospital.
 St. Michael's Hospital.
 MINOT
 St. Joseph's Hospital.
 Trinity Hospital.
 VALLEY CITY, (c) Mercy Hospital.
 WILLISTON, (c) Mercy Hospital.

OHIO

AKRON
 Children's Hospital.
 City Hospital of Akron.
 Peoples Hospital.
 St. Thomas Hospital.
 ALLIANCE, Alliance City Hospital.
 ASHTABULA, (c) Ashtabula General Hospital.
 BELLAIRE, City Hospital.
 CANTON
 Aultman Hospital.
 Mercy Hospital.
 CHILLICOTHE, Veterans' Administration Hospital.
 CINCINNATI
 Bethesda Hospital.
 Children's Hospital.
 Christ Hospital.
 Christian R. Holmes Hospital.
 Cincinnati General Hospital.
 Deaconess Hospital.
 Good Samaritan Hospital.
 Hamilton County Tuberculosis Sanatorium.
 Jewish Hospital.
 St. Mary Hospital.
 CIRCLEVILLE, (c) Berger Municipal Hospital.
 CLEVELAND
 Babies' and Children's Hospital.
 Charity Hospital.
 City Hospital.
 Cleveland Clinic Hospital.
 Evangelical Deaconess Hospital.
 Fairview Park Hospital.
 Glenville Hospital.
 Grace Hospital.
 Huron Road Hospital.
 Lakeside Hospital.
 Lutheran Hospital.
 Maternity Hospital.
 Mount Sinai Hospital of Cleveland.
 Polyclinic Hospital.
 St. Alexis Hospital.
 St. Ann's Maternity Hospital.
 St. John's Hospital of Cleveland.
 St. Luke's Hospital.
 United States Marine Hospital.
 Woman's Hospital.

COLUMBUS
 Children's Hospital.
 Grant Hospital.
 Hawkes Hospital of Mt. Carmel.
 Mercy Hospital.
 St. Ann's Infant Asylum and Maternity Hospital.
 St. Francis Hospital.
 Starling-Loving University Hospital.
 White Cross Hospital.

DAYTON
 Miami Valley Hospital.
 St. Elizabeth Hospital.
 Veterans' Administration Hospital.

DOVER, Union Hospital.
 EAST AKRON, Springfield Lake Sanatorium.

EAST LIVERPOOL, East Liverpool City Hospital.

ELYRIA, Elvria Memorial Hospital and Gates Hospital for Crippled Children.

FINDLAY, (c) Home and Hospital of the City of Findlay.

FREMONT, (c) Memorial Hospital of Sandusky County.

GALLIPOLIS, Holzer Hospital.

HAMILTON
 (c) Fort Hamilton Hospital.
 Mercy Hospital.

LAKEWOOD, Lakewood City Hospital.

LIMA
 Lima Hospital.
 St. Rita's Hospital.

LORAIN, St. Joseph's Hospital.

MANSFIELD, Mansfield General Hospital.

MARION, Sawyer Sanatorium.

MARTINS FERRY, Martins Ferry Hospital.

MASSILLON, Massillon City Hospital.

MIDDLETOWN, Middletown Hospital.

NEWARK, Newark Hospital.

OBERLIN, Allen Hospital.

Piqua, Memorial Hospital.

PORTSMOUTH
 Mercy Hospital.
 Portsmouth General Hospital.
 Schirman Hospital.

SALEM, Salem City Hospital.

SANDUSKY
 Good Samaritan Hospital.
 Providence Hospital.

SIDNEY, (c) Wilson Memorial Hospital.
 SOUTH EUCLID, Rainbow Hospital.
 SPRINGFIELD, Springfield City Hospital.
 STEUBENVILLE, Ohio Valley Hospital.

TOLEDO
 Flower Hospital.
 Lucas County Hospital.
 Mercy Hospital.
 Robinwood Hospital.
 St. Vincent's Hospital.
 Toledo Hospital.
 Women's and Children's Hospital.

TROY, (c) Stouder Memorial Hospital.

WARREN
 St. Joseph's Riverside Hospital.
 Warren City Hospital.

WAUSEON, De Ette Harrison Detwiler Memorial Hospital.

YOUNGSTOWN
 St. Elizabeth's Hospital.
 Youngstown Hospital.

ZANESVILLE
 Bethesda Hospital.
 Good Samaritan Hospital.

OKLAHOMA

ARDMORE, Hardy Sanitarium.

BARTLESVILLE, Washington County Memorial Hospital.

CLAREMORE, Claremont Indian Hospital.

CLINTON, (c) Clinton Hospital.

EL RENO, El Reno Sanitarium.

LAWTON, Kiowa Indian Hospital.

MCALISTER, Albert Pike Hospital.

MUSKOGEE
 (c) Oklahoma Baptist Hospital.
 Veterans' Administration Hospital.

OKLAHOMA CITY
 Oklahoma City General Hospital.
 Reconstruction Hospital and McBride Clinic.

St. Anthony's Hospital.
 (c) Samaritan Hospital.

University Hospitals:
 University Hospital.
 Crippled Children's Hospital.

Wesley Hospital.

PAWNEE, Pawnee-Ponca Hospital.

PICHER, American Hospital.

PONCA CITY, Ponca City Hospital.

SHAWNEE
 A. C. H. Hospital.
 Shawnee Indian Sanatorium.
 Shawnee Municipal Hospital.

SULPHUR, (c) Soldiers' Tubercular Sanatorium.

TULSA
 Morningside Hospital.
 St. John's Hospital.

OREGON

ASTORIA
 Columbia Hospital.
 St. Mary's Hospital.

BAKER, (c) St. Elizabeth's Hospital.

CORVALLIS, Corvallis General Hospital.

EUGENE
 Eugene Hospital and Clinic.
 Pacific Christian Hospital.

KLAMATH FALLS
 (c) Hillside Hospital.
 (c) Klamath Valley Hospital.

MEDFORD, Sacred Heart Hospital.

ONTARIO, Holy Rosary Hospital.

OREGON CITY, Oregon City Hospital.

PENDLETON, St. Anthony's Hospital.

PORTLAND
 Dr. Robert C. Coffey Clinic and Hospital.

Doernbecher Memorial Hospital for Children.

Emanuel Hospital.

Good Samaritan Hospital.

Multnomah Hospital.

Portland Medical Hospital.

Portland Sanitarium and Hospital.

St. Vincent's Hospital.

Shriners' Hospital for Crippled Children.

Veterans' Administration Hospital.

SALEM, Salem General Hospital.

PENNSYLVANIA

ABINGTON, Abington Memorial Hospital.

ALLENTOWN
 Allentown Hospital.
 Sacred Heart Hospital.

ALTOONA
 Altoona Hospital.
 Mercy Hospital.

ASHLAND, Ashland State Hospital.

ASPINWALL, Veterans' Administration Hospital.

BEAVER FALLS, Providence Hospital.

BELLEVUE, Suburban General Hospital.

BETHLEHEM, St. Luke's Hospital.

BLOOMSBURG, Bloomsburg Hospital.

BLOSSBURG, (c) Blossburg State Hospital.

BRADDOCK, Braddock General Hospital.

BRADFORD, Bradford Hospital.

BROWNSVILLE, Brownsville General Hospital.

BRYN MAWR, Bryn Mawr Hospital.

CANONSBURG, Canonsburg General Hospital.

CARLISLE, Carlisle Hospital.

CHAMBERSBURG, Chambersburg Hospital.

CHESTER
 Chester Hospital.
 J. Lewis Crozer Homeopathic Hospital.

CLEARFIELD, Clearfield Hospital.

COALDALE, (c) Coaldale State Hospital.

COATESVILLE
 Coatesville Hospital.
 Veterans' Administration Hospital.

COLUMBIA, (c) Columbia Hospital.

CONNELLSVILLE, Connelville State Hospital.

CORRY, (c) Corry Hospital.

DANVILLE, George F. Geisinger Memorial Hospital.

DREXEL HILL, Delaware County Hospital.

DU BOIS
 Du Bois Hospital.
 Maple Avenue Hospital.

EASTON, Easton Hospital.

ERIE
 Hamot Hospital.
 St. Vincent's Hospital.

FRANKLIN, (c) Franklin Hospital.

GETTYSBURG, Annie M. Warner Hospital.

GREENSBURG, Westmoreland Hospital.

HANOVER, Hanover General Hospital.

HARRISBURG
 Harrisburg Hospital.
 Harrisburg Polyclinic Hospital.

HAZLETON, Hazleton State Hospital.

HOMESTEAD, Homestead Hospital.

HUNTINGTON, J. C. Blair Memorial Hospital.

INDIANA, Indiana Hospital.

JOHNSTOWN
 Cambria Hospital.
 Conemaugh Valley Memorial Hospital.

Lee Homeopathic Hospital.

Mercy Hospital of Johnstown.

KANE
 Community Hospital.
 (c) Kane Summit Hospital.

KINGSTON, Nesbit Memorial Hospital.

LANCASTER
 Lancaster General Hospital.
 St. Joseph's Hospital.

LEAGUE ISLAND, United States Naval Hospital.

LEBANON, Good Samaritan Hospital.

LEWISTOWN, Lewistown Hospital.

LOCK HAVEN, Lock Haven Hospital.

MAYVIEW, Pittsburgh City Home and Hospitals.

MCKEESPORT, McKeesport Hospital.

MCKEES ROCKS, Ohio Valley General Hospital.

MEADVILLE, Spencer Hospital.

NANTICOKE, Nanticoke State Hospital.

NEW BRIGHTON, Beaver Valley General Hospital.

NEW CASTLE
 Jameson Memorial Hospital.
 New Castle Hospital.

NEW EAGLE, Memorial Hospital of Monongahela.

NEW KENSINGTON, Citizens General Hospital.

NORRISTOWN, Montgomery Hospital.

OIL CITY, Oil City General Hospital.

PALMERTON, Palmerton Hospital.

PHILADELPHIA
 American Hospital for Diseases of the Stomach.
 American Oncologic Hospital.

Broad Street Hospital.

Chestnut Hill Hospital.

Children's Hospital of Philadelphia.

Children's Hospital of the Mary J. Drexel Home.

Frankford Hospital.

Garretson Hospital of Temple University.

Germantown Dispensary and Hospital.

Graduate Hospital of the University of Pennsylvania.

Hahnemann Medical College Hospital.

Hospital Lankenau.

Hospital of the Protestant Episcopal Church of Philadelphia.

Hospital of the University of Pennsylvania.

Hospital of the Woman's Medical College of Pennsylvania.

Jeane's Hospital.

Jefferson Hospital.

Jewish Hospital.

Joseph Price Memorial Hospital.

Kensington Hospital for Women.

Memorial Hospital.

Mercy Hospital.

Methodist Episcopal Hospital.

Misericordia Hospital.

Mount Sinai Hospital.

Northeastern Hospital of Philadelphia.

Northern Liberties Hospital.

Northwestern General Hospital.

Pennsylvania Hospital.

Philadelphia General Hospital.

Philadelphia Orthopaedic Hospital and Infirmary for Nervous Diseases.

Presbyterian Hospital in Philadelphia.

St. Agnes Hospital.

St. Christopher's Hospital for Children.

St. Joseph's Hospital.

St. Luke's and Children's Homeopathic Hospitals.

St. Mary's Hospital.

St. Vincent's Hospital for Women and Children.

Shriners' Hospital for Crippled Children.

Stetson Hospital.

Temple University Hospital.

Veterans' Administration Hospital.

Wills Hospital.

Woman's Hospital of Philadelphia.

Women's Homeopathic Hospital of Philadelphia.

PHILIPSBURG, Philipsburg State Hospital.

PITTSBURGH
 Allegheny General Hospital.
 Children's Hospital of Pittsburgh.

Elizabeth Steel Magee Hospital.

Eye and Ear Hospital.

Homeopathic Medical and Surgical Hospital and Dispensary.

Mercy Hospital.

Montefiore Hospital.

Passavant Hospital.

Pittsburgh Hospital.

Presbyterian Hospital.

Roselia Foundling Asylum and Maternity Hospital.

St. Francis Hospital.

St. John's General Hospital of Allegheny City.

St. Joseph's Hospital and Dispensary.

St. Margaret Memorial Hospital.

South Side Hospital.

Tuberculosis League Hospital.

United States Marine Hospital.

Western Pennsylvania Hospital.

PITTSBURGH, Pittston Hospital.

POTTSTOWN, Pottstown Hospital.

POTTSVILLE, Pottsville Hospital.

READING
 Homeopathic Medical and Surgical Hospital.

Reading Hospital.

St. Joseph's Hospital.

RIDLEY PARK, Taylor Hospital.

ROARING SPRING, (c) Nason Hospital.

ROCHESTER, Rochester General Hospital.

SAYRE, Robert Packer Hospital.

SCRANTON
 Hahnemann Hospital.
 Mercy Hospital.

Moses Taylor Hospital.

St. Joseph's Children's and Maternity Hospital.

Scranton State Hospital.

SELLERSVILLE, Grand View Hospital.

SEWICKLEY, Valley Hospital.

SHAMOKIN, Shamokin State Hospital.

SHARON, Christian H. Buhl Hospital.

TARENTUM, Allegheny Valley Hospital.

UNIONTOWN, Uniontown Hospital.

WARREN, Warren General Hospital.

WASHINGTON, Washington Hospital.

WAYNESBORO, (c) Waynesboro Hospital.

WEST CHESTER
 Chester County Hospital.
 Homeopathic Hospital of Chester County.

WILKES-BARRE
 Mercy Hospital.
 Wilkes-Barre General Hospital.

WILKINSBURG, Columbia Hospital.

WILLIAMSPORT, Williamsport Hospital.

WINDBER, Windber Hospital.

YORK
 West Side Sanitarium.
 York Hospital.

RHODE ISLAND

NEWPORT
 Newport Hospital.

United States Naval Hospital.

PAWTUCKET, Memorial Hospital.

PROVIDENCE
 Charles V. Chapin Hospital.

Homeopathic Hospital of Rhode Island.

Miriam Hospital.

Providence Lying-in Hospital.

Rhode Island Hospital.

St. Joseph's Hospital.

WESTERLY, Westerly Hospital.

WOONSOCKET, (c) Woonsocket Hospital.

SOUTH CAROLINA

ANDERSON, Anderson County Hospital.

BENNETTSVILLE, Marlboro County General Hospital.

CHARLESTON
Baker Sanatorium.
Roper Hospital.
St. Francis Xavier Infirmary.
United States Naval Hospital.

COLUMBIA
Columbia Hospital of Richland County.
South Carolina Baptist Hospital.

FLORENCE
McLeod Infirmary.
(c) Saunders Memorial Hospital.

GREENVILLE
Greenville City Hospital.
Shriners' Hospital for Crippled Children.

ORANGEBURG, Orangeburg Hospital.

PARRIS ISLAND, United States Naval Hospital.

SPARTANBURG
Mary Black Clinic and Private Hospital.
Spartanburg General Hospital.
Sumter, Tuomey Hospital.

TAYLORS, Chick Springs Hotel—Sanitarium.

SOUTH DAKOTA

ABERDEEN, St. Luke's Hospital.

CHAMBERLAIN, Chamberlain Sanitarium and Hospital.

DEADWOOD, St. Joseph's Hospital.

HOT SPRINGS, Veterans' Administration Hospital.

HURON, Sprague Hospital.

LEAD, Homestake Hospital.

MADISON, New Madison Hospital.

MITCHELL
Methodist State Hospital.
St. Joseph's Hospital.

PIERRE, St. Mary's Hospital.

RAPID CITY
Black Hills Methodist Hospital.
St. John's Hospital.

SIoux FALLS
McKenna Hospital.
(c) Moe Hospital.

SIoux Valley Hospital.

WATERTOWN
Barton Hospital.
Luther Hospital.

WEBSTER, Peabody Hospital.

YANKTON, Sacred Heart Hospital.

TENNESSEE

BOLIVAR, Western State Hospital.

CHATTANOOGA
Baroness Erlanger Hospital.
Children's Hospital.
Newell and Newell Sanitarium.
Pine Breeze Sanitarium.

DYERSBURG, Baird-Brewer General Hospital.

GREENEVILLE, Greeneville Sanatorium and Hospital.

JACKSON
(c) Crook Sanatorium.
(c) Memorial Hospital.

JOHNSON CITY
Appalachian Hospital.
Veterans' Administration Hospital.

KNOXVILLE
Fort Sanders Hospital.
Knoxville General Hospital.
St. Mary's Memorial Hospital.

MADISON, Madison Rural Sanitarium.

MEMPHIS
Baptist Memorial Hospital.
Gartly-Ramsay Hospital.
Hospital for Crippled Adults.
Memphis Eye, Ear, Nose, and Throat Hospital.
Memphis General Hospital.
Methodist Hospital.
St. Joseph's Hospital.
United States Marine Hospital.
Veterans' Administration Hospital.

WILLIS C. CAMPBELL CLINIC HOSPITAL.

MURFREESBORO, Rutherford Hospital.

NASHVILLE
Barr Infirmary.
George W. Hubbard Hospital.
Millie E. Hale Hospital.
Nashville General Hospital.
Protestant Hospital.
St. Thomas Hospital.
Vanderbilt University Hospital.

TEXAS

ABILENE, West Texas Baptist Sanitarium.

AMARILLO
Northwest Texas Hospital.
St. Anthony's Sanitarium.

AUSTIN, Seton Infirmary.

BEAUMONT
Beaumont General Hospital.
Hotel Dieu.

BIG SPRINGS, Bivings and Barcus Hospital.

BROWNWOOD, Medical Arts Hospital.

CORPUS CHRISTI
Fred Roberts Memorial Hospital.
Spohn Sanitarium.

CUERO, Burns Hospital.

DALLAS
Baylor University Hospital.
Bradford Memorial Hospital for Babies.
Dallas Medical and Surgical Clinic Hospital.
Dallas Methodist Hospital.
Parkland Hospital.
Rushing Clinic and Sanitarium.
St. Paul's Hospital.
Texas Scottish Rite Hospital for Crippled Children.

DENISON, (c) Missouri, Kansas and Texas Railroad Employees' Hospital.

EL PASO
(c) El Paso City-County Hospital.
El Paso Masonic Hospital.
Hotel Dieu Sisters' Hospital.
William Beaumont General Hospital.

FORT SAM HOUSTON, Station Hospital.

FORT WORTH
All Saints Hospital.
(c) Baptist Hospital of Fort Worth.
(c) City and County Hospital.
Harris Clinic-Hospital.
Methodist Hospital of Fort Worth.
St. Joseph's Infirmary.
W. I. Cook Memorial Hospital.

GALVESTON
John Sealy Hospital.
St. Mary's Infirmary.
United States Marine Hospital.

HILLSBORO, (c) Boyd Sanitarium.

HOUSTON
Hermann Hospital.
Jefferson Davis Hospital.
Memorial Hospital.
Methodist Hospital.
St. Joseph's Infirmary.
Southern Pacific Hospital.

JACKSONVILLE, Nan Travis Hospital.

LAKED, Mercy Hospital.

LEGION, Veterans' Administration Hospital.

LUBBOCK
(c) Lubbock Sanitarium.
(c) West Texas Hospital.

MARLIN, Torbett Sanatorium and Clinic.

MARSHALL, Texas and Pacific Railway Employees' Hospital.

McKINNEY, McKinney City Hospital.

MINERAL WELLS, (c) Nazareth Hospital.

ORANGE, (c) Frances Ann Litcher Hospital.

PALESTINE, International and Great Northern Railway Employees' Hospital.

PARIS
St. Joseph's Infirmary.
Sanitarium of Paris.

PORT ARTHUR, St. Mary's Hospital.

Gates Memorial.

PRAIRIE VIEW, (c) Prairie View Hospital.

SAN ANGELO
(c) St. John's Hospital.
(c) Shannon West Texas Memorial Hospital.

SAN ANTONIO
Medical and Surgical Hospital.
Nix Hospital.
Robert B. Green Memorial Hospital.
Santa Rosa Hospital.

SANTA ANNA, Sealy Hospital.

SHERMAN
St. Vincent's Sanitarium.
(c) Wilson N. Jones Hospital.

SLATON, (c) Mercy Hospital.

TEMPLE
Gulf, Colorado and Santa Fe Hospital.
King's Daughters' Hospital.
Scott and White Hospital.

TEXARKANA, Texarkana Hospital.

WACO
Central Texas Baptist Sanitarium.
Colgin Hospital and Clinic.
Providence Sanitarium.
Veterans' Administration Hospital.

WAXAHACHIE, Waxahachie Sanitarium.

WICHITA FALLS
Wichita Falls Clinic-Hospital.
Wichita General Hospital.

UTAH

LOGAN, William Budge Memorial Hospital.

OGDEN, Thomas D. Dee Memorial Hospital.

SALT LAKE CITY
Dr. W. H. Groves Latter Day Saints Hospital.
Holy Cross Hospital.
St. Mark's Hospital.
Salt Lake General Hospital.
Veterans' Administration Hospital.

VERMONT

BARRE, (c) Barre City Hospital.

BRATTLEBORO, Brattleboro Memorial Hospital.

BURLINGTON
Bishop de Goesbriand Hospital.
Mary Fletcher Hospital.

MIDDLEBURY, Porter Hospital.

MONTPELIER, Heaton Hospital.

RUTLAND, Rutland Hospital.

ST. ALBANS, St. Albans Hospital.

ST. JOHNSBURY, Brightlook Hospital.

WINOOSKI, Fanny Allen Hospital.

VIRGINIA

ABINGDON, George Ben Johnston Memorial Hospital.

CLIFTON FORGE, Chesapeake and Ohio Hospital.

DANVILLE, (c) Memorial Hospital.

FARMVILLE, Southside Community Hospital.

HAMPTON
Hampton Training School for Nurses and Dixie Hospital.
Veterans' Administration Hospital.

LYNCHBURG
Lynchburg Hospital.
Marshall Lodge Memorial Hospital.
Virginia Baptist Hospital.

NEWPORT NEWS
Elizabeth Buxton Hospital.
Riverside Hospital.

NORFOLK
Hospital of St. Vincent de Paul.
Memorial Hospital of Norfolk.
Norfolk Protestant Hospital.
Sarah Leigh Hospital.
United States Marine Hospital.
United States Naval Hospital.

PETERSBURG
Medical Center-Central State Hospital.
Petersburg Hospital.

PORTSMOUTH
King's Daughters' Hospital.
Parish Memorial Hospital.

RICHMOND
Crippled Children's Hospital.
Grace Hospital.
Johnston-Willis Hospital.
Medical College of Virginia, the Memorial, the Dooley and St. Philip Hospitals.
Retreat for the Sick.
St. Elizabeth's Hospital.
St. Luke's Hospital.
Sheltering Arms Hospital.
Stuart Circle Hospital.
Tucker Sanatorium.

ROANOKE
(c) Burrell Memorial Hospital.
Gill Memorial Eye, Ear, and Throat Hospital.
Jefferson Hospital.
Lewis-Gale Hospital.
Roanoke Hospital.
Shenandoah Hospital.

STAUNTON, King's Daughters' Hospital.

SUFFOLK, Lakeview Hospital.

UNIVERSITY, University of Virginia Hospital.

WINCHESTER, Winchester Memorial Hospital.

WASHINGTON

ABERDEEN
Grays Harbor Hospital.
St. Joseph's Hospital.

AMERICAN LAKE, Veterans' Administration Hospital.

BELLINGHAM
St. Joseph's Hospital.
St. Luke's Hospital.

BREMERTON, Puget Sound, United States Naval Hospital.

CHEHALIS, (c) St. Helen's Hospital.

COLFAX, (c) St. Ignatius Hospital.

ELLENSBURG, Ellensburg General Hospital.

EVERETT
General Hospital of Everett.
Providence Hospital.

OLYMPIA, St. Peter's Hospital.

PASCO, Our Lady of Lourdes Hospital.

PORT ANGELES, Port Angeles Hospital and Sanitarium.

PORT TOWNSEND, United States Marine Hospital.

SEATTLE
Children's Orthopedic Hospital.
Columbus Hospital.
Harborview Hospital.
Martha Washington Hospital.
Providence Hospital.
St. Luke's Hospital.
Seattle General Hospital.
Swedish Hospital.
Virginia Mason Hospital.

SHELTON, (c) Shelton General Hospital.

SPOKANE
Deaconess Hospital.
Sacred Heart Hospital.
St. Luke's Hospital.
Shriners' Hospital for Crippled Children—Mobile Unit.

TACOMA
Northern Pacific Beneficial Association Hospital.
Pierce County Hospital.
St. Joseph's Hospital.
Tacoma General Hospital.
U. S. Tacoma Hospital.

VANCOUVER
Clark General Hospital.
St. Joseph's Hospital.

WALLA WALLA
St. Mary's Hospital.
Veterans' Administration Hospital.
Walla Walla Sanitarium and Hospital.

WENATCHEE
Central Washington Deaconess Hospital.
St. Anthony's Hospital.

YAKIMA, St. Elizabeth's Hospital.

WEST VIRGINIA

BECKLEY, Beckley Hospital.

BLUEFIELD
Bluefield Sanitarium.
St. Luke's Hospital.

CHARLESTON
Kanawha Valley Hospital.
McMillan Hospital.
Mountain State Hospital.
New Charleston General Hospital.

CLARKSBURG
Mason Hospital.
St. Mary's Hospital.

ELKINS
Davis Memorial Hospital.
Elkins City Hospital.

FAIRMONT
(c) Cook Hospital.
Fairmont Emergency Hospital.

GLENDALE, Reynolds Memorial Hospital.

HOPMONT, (c) Hopmont Sanitarium.

HUNTINGTON
Chesapeake and Ohio Hospital.
Huntington Memorial Hospital.
St. Mary's Hospital.

LAKIN, (c) Lakin State Hospital.

LOGAN, Hatfield-Lawson Hospital.

MARTINSBURG
City Hospital.
(c) King's Daughters' Hospital.

MONTGOMERY, Coal Valley Hospital.

MORGANTOWN, (c) Monongalia County Hospital.

OAK HILL, Oak Hill Hospital.

PARKERSBURG
(c) Camden-Clark Hospital.
(c) St. Joseph's Hospital.

PRINCETON, Mercer Memorial Hospital.

RONCEVERTE, Greenbrier Valley Hospital.

WELCH
Stevens Clinic Hospital.
Welch Emergency Hospital.

WHEELING
Ohio Valley General Hospital.
Wheeling Hospital.

WISCONSIN

APPLETON, St. Elizabeth Hospital.

ASHLAND
(c) Ashland General Hospital.
St. Joseph's Hospital.

BELOIT, Beloit Municipal Hospital.

DODGEVILLE, St. Joseph's Hospital.

EAU CLAIRE, Luther Hospital.

FOND DU LAC, St. Agnes Hospital.

GREEN BAY
Bellin Memorial Hospital.
St. Mary's Hospital.

JANESVILLE, Mercy Hospital.

KENOSHA
Kenosha Hospital.
St. Catherine's Hospital.

LA CROSSE
Grandview Hospital.
La Crosse Hospital.
La Crosse Lutheran Hospital.
St. Francis Hospital.

MADISON
Madison General Hospital.
Methodist Hospital.
St. Mary's Hospital.
State of Wisconsin General Hospital.
Wisconsin Orthopedic Hospital for Children.

MANITOWOC, Holy Family Hospital.

MARSHFIELD, St. Joseph's Hospital.

MILWAUKEE
Columbia Hospital.
Evangelical Deaconess Hospital.
Johnston Emergency Hospital.
Milwaukee Children's Hospital.
Milwaukee General Hospital.
Milwaukee Hospital.
Misericordia Hospital.
Mount Sinai Hospital.
Sacred Heart Sanitarium.
St. Joseph's Hospital.
St. Luke's Hospital.
St. Mary's Hospital.
Veterans' Administration Hospital.

NEENAH, Theda Clark Memorial Hospital.

OSHKOSH, Mercy—St. Mary's Hospital.
 RACINE
 St. Luke's Hospital.
 St. Mary's Hospital.
 STEVENS POINT, St. Michael's Hos-
 pital.
 SUPERIOR, St. Mary's Hospital.
 WAUSAU
 St. Mary's Hospital.
 Wausau Memorial Hospital.
 WAUWATOSA
 Milwaukee County Hospital.
 Muirdale Sanatorium.

WYOMING

CASPER, Memorial Hospital of Natrona
 County.
 CHEYENNE, Memorial Hospital of
 Laramie County.
 MIDWEST, Midwest Hospital.
 SHERIDAN
 Sheridan County Memorial Hospital.
 Veterans' Administration Hospital.
 WHEATLAND, Wheatland General Hos-
 pital.

ALASKA

FORT YUKON, Hudson Stuck Memorial
 Hospital.

CANAL ZONE

ANCON, Gorgas Hospital.

HAWAII

HILO, Hilo Memorial Hospital.
 HONOLULU
 (c) Japanese Hospital.

(c) Kauaikealani Children's Hospital.
 Leahi Home.
 Queen's Hospital.
 St. Francis Hospital.
 Shriners' Hospital for Crippled Chil-
 dren.

PANAMA

PANAMA, Hospital Santo Tomas.

PORTO RICO

SAN JUAN, Presbyterian Hospital.

Canadian Hospitals on Approved List

ALBERTA

BANFF, Banff Mineral Springs Hos-
 pital.
 CALGARY
 Calgary General Hospital.
 Colonel Belcher Hospital.
 Holy Cross Hospital.
 CAMROSE, St. Mary's Hospital.
 DRUMHELLER, Drumheller Municipal
 Hospital.
 EDMONTON
 Edmonton General Hospital.
 Misericordia Hospital.
 Royal Alexandra Hospital.
 University of Alberta Hospital.
 HANNA, (c) Hanna Municipal Hos-
 pital.
 LAMONT, Lamont Public Hospital.
 LETHBRIDGE
 Galt Hospital.
 St. Michael's Hospital.
 MEDICINE HAT, Medicine Hat General
 Hospital.
 RED DEER, Red Deer Municipal Hos-
 pital.
 STETTLE, (c) Stettler Municipal Hos-
 pital.
 VEGREVILLE, Vegreville General Hos-
 pital.

BRITISH COLUMBIA

CRANBROOK, (c) St. Eugene Hospital.
 ESSONDALE, Provincial Mental Hospital.
 KAMLOOPS, Royal Inland Hospital.
 KELOWNA, (c) Kelowna General Hos-
 pital.
 NEW WESTMINSTER, Royal Columbian
 Hospital.
 TRANQUILLE, Tranquille Sanatorium.
 VANCOUVER
 Grace Hospital.
 St. Paul's Hospital.
 Shaughnessy Hospital.
 Vancouver General Hospital.
 VICTORIA
 Provincial Royal Jubilee Hospital.
 St. Joseph's Hospital.

MANITOBA

BRANDON, Brandon General Hospital.
 NINETTE, Manitoba Sanatorium Hos-
 pital.
 ST. BONIFACE, St. Boniface Hospital.
 WINNIPEG
 Children's Hospital of Winnipeg.
 Grace Hospital.
 Misericordia Hospital.
 Municipal Hospitals:
 King Edward Memorial Hospital.
 King George Hospital.
 St. Joseph's Hospital.
 Shriners' Hospital for Crippled Chil-
 dren—Mobile Unit.
 (c) Victoria Hospital.
 Winnipeg General Hospital.

NEW BRUNSWICK

CAMPBELLTON
 Hotel Dieu Hospital.
 Restigouche and Bay Chaleur Sol-
 diers' Memorial Hospital.
 CHATHAM, Hotel Dieu Hospital.
 FREDERICTON, Victoria Public Hospital.
 MONCTON
 Hotel Dieu de l'Assomption.
 Moncton Hospital.
 NEWCASTLE, Miramichi Hospital.
 ST. BASIL, Hotel Dieu of St. Joseph.
 SAINT JOHN
 Lancaster Hospital.
 Saint John County Hospital.
 Saint John General Hospital.
 Saint John Infirmary.
 ST. STEPHEN, Chipman Memorial Hos-
 pital.
 TRACADIE, Hotel Dieu of St. Joseph.
 WOODSTOCK, (c) Carleton County L.
 P. Fisher Memorial Hospital.

NOVA SCOTIA

AMHERST, Highland View Hospital.
 ANTIGONISH, St. Martha's Hospital.
 GLACE BAY
 Glace Bay General Hospital.
 St. Joseph's Hospital.
 HALIFAX
 Camp Hill Hospital.
 (c) Children's Hospital.
 Grace Maternity Hospital.
 Halifax Infirmary.
 Victoria General Hospital.
 KENTVILLE, Nova Scotia Sanatorium.
 NEW GLASGOW, Aberdeen Hospital.
 NEW WATERFORD, New Waterford
 General Hospital.
 SYDNEY
 (c) St. Rita Hospital.
 Sydney City Hospital.
 SYDNEY MINES, (c) Harbor View
 Hospital.
 TRURO, Colchester County Hospital.
 YARMOUTH NORTH, (c) Yarmouth Hos-
 pital.

ONTARIO

BRANTFORD, Brantford General Hos-
 pital.
 BROCKVILLE
 (c) Brockville General Hospital.
 (c) St. Vincent de Paul Hospital.
 BYRON, Queen Alexandra Sanatorium.
 CHATHAM
 Public General Hospital.
 St. Joseph's Hospital.
 CORNWALL
 (c) Cornwall General Hospital.
 (c) Hotel Dieu Hospital.
 FORT WILLIAM, McKellar General Hos-
 pital.
 GALT, Galt General Hospital.
 GRAVENHURST, Muskoka Hospital for
 Consumptives.
 GUELPH, (c) St. Joseph's Hospital.
 HAMILTON
 Hamilton General Hospital.
 Mountain Sanatorium.
 St. Joseph's Hospital.
 KINGSTON
 Hotel Dieu Hospital.
 Kingston General Hospital.
 KITCHENER, St. Mary's Hospital.
 LONDON
 St. Joseph's Hospital.
 Victoria Hospital.
 Westminster Hospital.
 NIAGARA FALLS, Niagara Falls General
 Hospital.
 OSHAWA, Oshawa General Hospital.
 OTTAWA
 Ottawa Civic Hospital.
 Ottawa General Hospital.
 OWEN SOUND, General and Marine
 Hospital.
 PETERBORO
 Nicholls Hospital.
 St. Joseph's Hospital.
 PORT ARTHUR, St. Joseph's General
 Hospital.
 ST. CATHARINES, St. Catharines Gen-
 eral Hospital.
 ST. THOMAS, Memorial Hospital.
 SAULT STE. MARIE, General Hospital.
 SMITHS FALLS
 (c) St. Francis General Hospital.
 (c) Smiths Falls Public Hospital.
 STRATFORD, Stratford General Hospital.
 SUDBURY, St. Joseph's Hospital.
 TORONTO
 Christie Street Hospital.
 Grace Hospital Division of the To-
 ronto Western Hospital.
 Hospital for Sick Children.
 Lockwood Clinic Hospital.
 Riverdale Isolation Hospital.
 St. Joseph's Hospital.
 St. Michael's Hospital.
 Toronto East General Hospital.
 Toronto General Hospital.
 Toronto Western Hospital.
 Wellesley Hospital.
 Women's College Hospital.
 WALKERVILLE, Metropolitan General
 Hospital.
 WESTON, Toronto Hospital for Con-
 sumptives.
 WINDSOR
 Hotel Dieu of St. Joseph.
 Salvation Army Grace Hospital.
 WOODSTOCK, Woodstock General Hos-
 pital.

PRINCE EDWARD ISLAND

CHARLOTTETOWN
 Charlottetown Hospital.
 Prince Edward Island Hospital.
 SUMMERSIDE, Prince County Hospital.

QUEBEC

LACHINE, (c) Lachine General Hos-
 pital.
 MONTREAL
 Alexandra Hospital.
 Children's Memorial Hospital.
 Homeopathic Hospital of Montreal.
 Hopital de la Misericorde and
 Catholic Maternity.
 Hopital Sainte Jeanne D'Arc.
 Hopital Sainte Justine, Pour Les En-
 fants.
 Hotel Dieu de Saint Joseph.
 L'Hopital Notre Dame.
 Montreal Foundling and Baby Hos-
 pital.
 Montreal General Hospital, Central
 Division.
 Montreal General Hospital, Western
 Division.
 Royal Victoria—Montreal Maternity
 Hospital.
 (c) Sacred Heart Hospital.
 Shriners' Hospital for Crippled Chil-
 dren.
 Woman's General Hospital.

QUEBEC
 Hopital de l'Enfant Jesus.
 Hopital du Saint Sacrement.
 Hotel Dieu du Precieux Sang.
 Jeffery Hale Hospital.
 ST. ANNE DE BELLEVUE, St. Anne de
 Bellevue Hospital.
 STE. FOY, Hospital Laval.
 ST. HYACINTHE, (c) St. Charles Hos-
 pital.
 SHERBROOKE
 Hopital General St. Vincent de Paul.
 Sherbrooke Hospital.
 TROIS RIVIERES, (c) Hopital St. Joseph.

SASKATCHEWAN

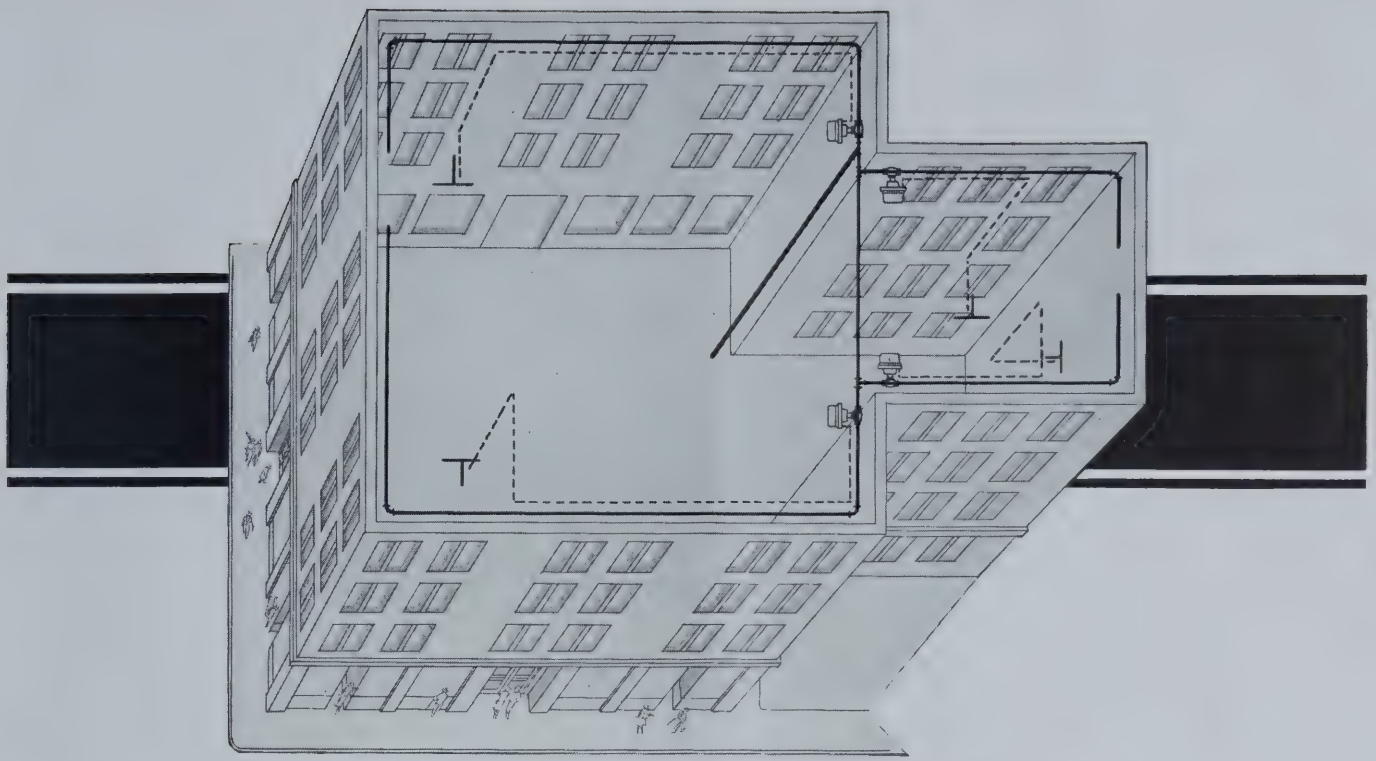
CANORA, (c) Hugh Waddell Memorial
 Hospital.
 FORT QU'APPELLE, Fort Qu'Appelle
 Sanatorium.
 HUMBOLDT, St. Elizabeth's Hospital.
 MACKLIN, (c) St. Joseph's Hospital.
 MOOSE JAW
 Moose Jaw General Hospital.
 Providence Hospital.
 NORTH BATTLEFORD, Notre Dame Hos-
 pital.
 PRINCE ALBERT
 Holy Family Hospital.
 Prince Albert Sanatorium.
 Victoria Hospital.
 REGINA
 Regina General Hospital.
 Regina Grey Nuns' Hospital.
 SASKATOON
 City Hospital.
 St. Paul's Hospital.
 Saskatoon Sanatorium.
 TISDALE, (c) St. Therese Hospital.

Approved Hospitals Elsewhere

AUSTRALIA—NEW SOUTH WALES: Lew-
 isham Hospital, Sydney; Newcastle
 Hospital, Newcastle; Royal Alexan-
 dra Hospital for Children, Camper-
 down, Sydney; Royal North Sydney
 Hospital, Sydney; Royal Prince Al-
 fred Hospital, Camperdown, Sydney;
 St. Vincent's Hospital, Sydney;
 Sydney Hospital, Sydney.
 VICTORIA, Alfred Hospital, Melbourne;
 Austin Hospital, Melbourne; Chil-
 dren's Hospital, Melbourne; Mel-

bourne Hospital, Melbourne; Queen's
 Memorial Hospital, Melbourne; St.
 Vincent's Hospital, Melbourne;
 Women's Hospital, Melbourne.
 CHINA, Peking Union Medical Col-
 lege Hospital, Peking.
 CUBA, Clinica Fortun-Souza, Havana;
 Francisco M. Fernandez Hospital,
 Havana; Instituto Del Cancer, Ha-
 vana.
 FRANCE, American Hospital, Paris.
 NEWFOUNDLAND, Notre Dame Bay

Memorial Hospital, Twillingate; St.
 Anthony Hospital, St. Anthony.
 NEW ZEALAND, Auckland Hospital,
 Auckland; Cashmere Sanatorium,
 Christchurch; Christchurch Hospi-
 tal, Christchurch; Dunedin Hospi-
 tal, Dunedin; Wellington Hospital, Wel-
 lington.
 URUGUAY, Gynecological Hospital
 (Pereira Rossell), Montevideo; Ma-
 ternity Hospital (Pereira Rossell),
 Montevideo.



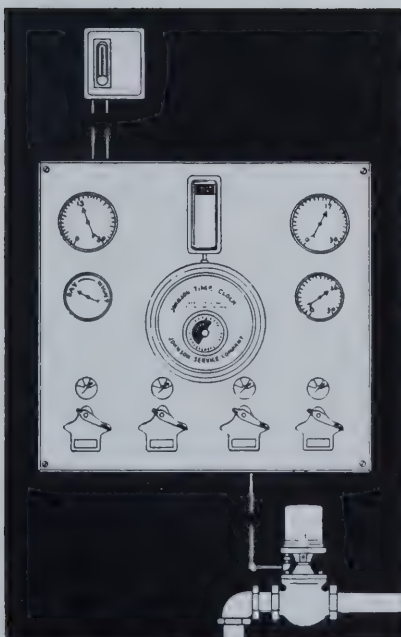
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The illustration suggests Johnson apparatus for a typical Zone Control System. Control panel applies to a building having four zones. Zone control valve and dual type thermostat for day and night operation are indicated for one of the zones.

FOODS AND FOOD SERVICE

“But You’ve Offered Cabbage Eight Times in Seven Days!”

Inability to Secure Desired Supplies Is One Factor in Failure to Provide Variety in Hospital Menus; Individual Likes and Dislikes Important, Too

By BERTHA E. BEECHER

Assistant Superintendent, The Christ Hospital, Cincinnati, O.

THE average person believes that menu planning has only reached its highest goal when every meal served is of such unusual attractiveness and variety that the surprise and delight of it is as great as was expressed in the old nursery rhyme:

“Sing a song of sixpence a pocket full of rye,
Four and twenty blackbirds baked in a pie;
When the pie was opened the birds began to sing,
Now wasn’t that a dainty dish to set before the king?”

However, such miracles in meal planning do not often happen; therefore, I would like to present a few simple facts which may be of some benefit in this discussion.

I fear it will still be a long time before even the small majority will accept a menu just because it contains proper food values, adequate tissue-forming and heat-producing material and sufficient vitamins and mineral salts to supply the demands of the body.

Variety, attractiveness, palatability spell success in meal planning in the mind of most folks.

It has been truly said that “You cannot please all the folks all the time, but you can please part of the folks all the time, and all of the folks part of the time.”

Some years ago a dietitian attempted to list the likes and dislikes of a hospital group, namely, doctors, patients, nurses and employees. A close study of this list revealed many interesting and fundamental facts. I presume it is needless to say that all of the groups registered their dislike for the much maligned spinach and

If you can overcome or alleviate difficulties caused by the following four factors you will gain in variety of menus, says Miss Beecher in this paper:

Likes and dislikes of individuals.

Limited budgets.

Lack of imagination.

Inability to secure desired supplies.

As an example of complications which sometimes follow the last handicap, Miss Beecher tells of an instance where cabbage was offered as substitute for unavailable items six times and in addition was served twice in a period of seven days.

carrots, while ice cream, pie and cake received an almost unanimous vote.

However, I noticed that age and type of occupation were evidently two very dominant factors in the selection of foods by these groups. We will agree, I think, that likes and dislikes are among the important hindrances to having a great variety in menus. It is one thing to serve a menu, but the obvious test is whether or not it is eaten and enjoyed.

In this list of likes and dislikes each group disliked at least three vegetables, but alas! not the same three. This illustrates one of the difficulties in keeping the variety wide in the planning of meals.

Another hindrance is the oftentimes prohibitive costs of certain foodstuffs. That tenderloin steak and mushrooms are not often used in making hospital menus is attributable not to the lack of desire of the dietitian to do so, but because of her

limited budget. This might also be said of many other foods.

Another hindrance to variety in menus is the evident lack of imagination displayed by the dietitian. However, I will grant that it takes more than imagination to produce variety in menu-making with the foodstuffs provided by some of the purveyors of hospitals.

One dietitian told me that she had had cabbage issued to her eight times in one week. Six times out of the eight this vegetable had been substituted for some other order. Another dietitian was compelled to use bananas a number of times in succession because the purchasing agent had bought a large quantity at a bargain. It is necessary literally to dream dreams and see visions in order to produce worthwhile menus.

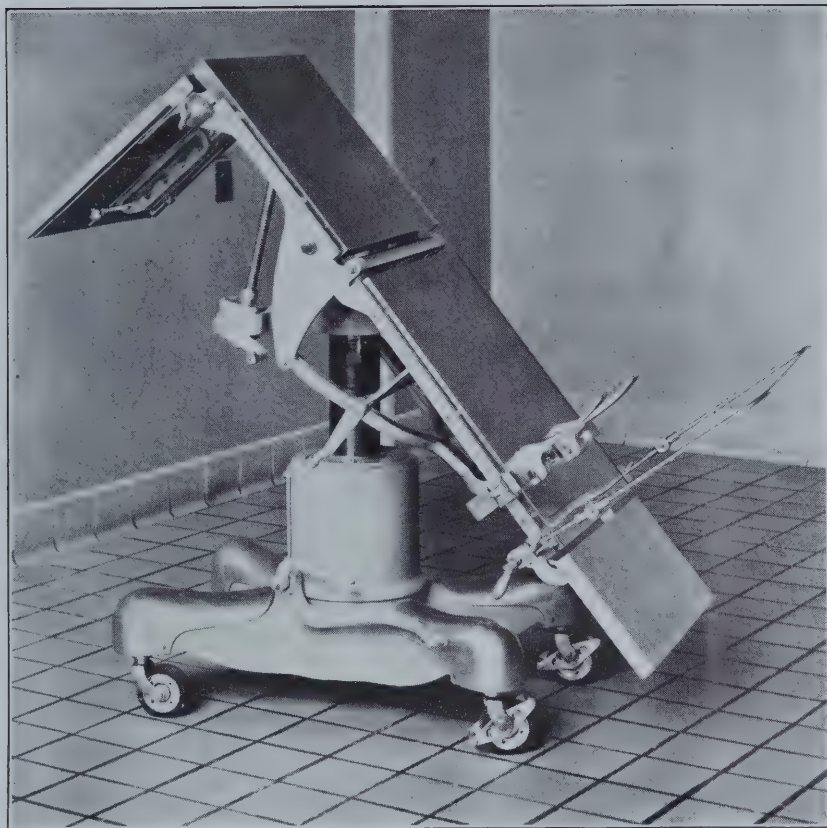
I presume I might go on at length and find many reasons why menus lack variety, but we have touched upon the outstanding ones.

1. Likes and dislikes to be considered.
2. Limited budgets.
3. Lack of imagination.
4. Inability to secure desired supplies.

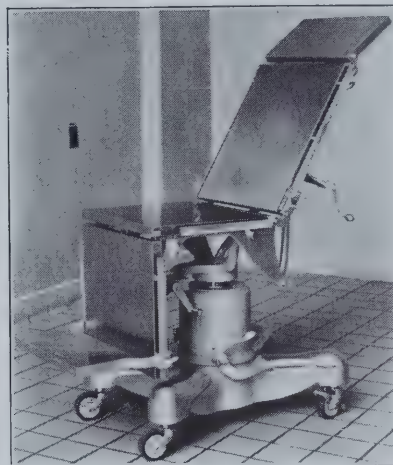
We have all faced the problem of variety many times. I suppose your chairman gave me this five minutes on your program with the hope that I would not spend all my time on diagnoses, but be able to suggest a remedy.

What, then, are some of the hopes for a wider variety in menu making? In the first place, the use of the element of surprise plays a large part in the building of satisfactory meals. Why should any institution have a specific day for serving certain dishes? I believe many of our New

From a paper before dietetic section, 1932 American Hospital Association convention.



Ideal *all-purpose* operating table. Takes the place of many special purpose tables, yet fills all general needs. Full adjustment from an extreme Trendelenburg (50°) angle to a chair position, including reverse Trendelenburg, Mayo kidney, reflex, g.u. and flat position. Entirely self-contained hydraulic hoist (an exclusive feature). Easy adjustment to all positions. Heavy, sturdy construction, yet exceptionally mobile. Moderate price.



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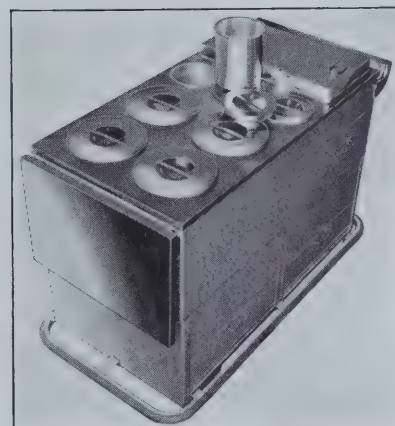
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Most hospitals use food conveyors. Most food conveyors are Ideals.



Above: Ideal dressing carriage. Below: Ideal, light, strong, sturdy wheeled stretcher.



THIS HALF...

Your Present China

PERHAPS your present china is not quite as lifeless or forbidding as we suggest. That isn't the point exactly. What we want you to realize is this—no china in use today, whether plain in pattern or decorated, has ever been so successful in bringing out the full brilliance of Nature's own coloring in foods, in making even the most depressing diet instantly appealing to the most stubborn appetite.

The hospital is, of all institutions, the one place where the taste stimulation of Adobe ware is going to be most widely appreciated. That we know already, because the simplest test quickly proves the effect upon the patient. Choose any diet, however plain. Serve it on Adobe ware. Place it before a patient, food-weary in the extreme. Watch his expression when he first sees the tray. Observe the relish with which he eats. And finally, count the food that is left.

We are fully aware of the financial strain many hospitals are being called upon to endure. We can appreciate their attitude toward new equipment, resulting from curtailed budgets. Nevertheless, we believe sincerely that no hospital can afford to allow present difficulties to blind them to the opportunity of earning the everlasting



Which Will a Patient

appreciation, the good will which an investment in this new Adobe ware confidently provides.

So sudden, so general has been the nationwide enthusiastic reception of Adobe ware that you may have some difficulty in locating a sizable stock of samples. You should find an assortment at leading supply dealers in all principal cities. If you do not locate a complete range of all the new patterns, please write us in Syracuse and we shall make sure that you are shown a representative number. Then, if you have any special design or shape in mind, let us know that too. Our designers would like nothing better than to start from scratch in creating a complete service that would be entirely yours. Any suggestions we might



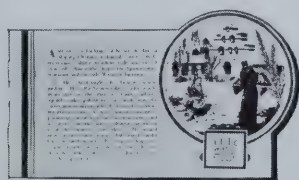
THIS HALF...

adobe ware

Be Eager to Eat?

make in the way of color specimens would be furnished, of course, without obligation or cost.

Onondaga Pottery Company, Syracuse, New York. *New York Offices:* 551 Fifth Avenue. *Chicago Offices:* 58 East Washington Street.



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“ . . . as essential as a meal . . . ”

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No higher praise, we feel, could come to any publication. No greater tribute to the unwavering editorial policy which has made Hospital Management “the *practical* journal of administration” could possibly be paid.

To serve those hospital executives who want practical, useful, definitely helpful ideas and suggestions which will aid them in their work has been the purpose of Hospital Management for sixteen years. To convey concrete, usable suggestions and ideas to interested, intelligent hospital executives shall continue to be the aim of Hospital Management in the future.

We hope that we shall in increasing measure deserve the description “. . . as essential as a meal . . . ”



Where Beauty Is More Than Skin Deep

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A not-to-be-overlooked service of John Sexton & Company to hotel and restaurant management, to the institutional steward or chef, is that of its Dietetic department. This is under the direction of one of America's leading dietitians. It is available to all in the solution of dietary problems confronted in planning the menu; it is also an ever active supervisory agent, counselling with and cooperating with all departments of John Sexton & Co. to insure constant purity and food values.

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The Visitor Who Stays Too Long



Keeps the patient here longer

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This is only one of the many practical uses of Hospital Posters.

No hospital can afford to be without this Hospital Poster Service at \$25.00 a year.

Hospital posters consist of 12 subjects:

- "Visitors who stay too long keep patients here longer."
- "Patients know silence is golden."
- "The Most Important Person in the Hospital."
- "Food is part of the treatment, too."
- "Where the Hospital Dollar Goes."
- "Children don't think—patients need quiet."
- "Wise visitors come and go on time."
- "X-ray, Laboratory cuts patients' stay."
- "The Hospital Baby Starts Life Right."
- "Let's all be quiet."
- "We're doing our best to speed this day." (Showing patient going home.)
- "Our Big Parade—They all Must be paid." (Stressing number of personnel at service of patients.)

A year's Hospital Poster service consists of 24 prints, two of each of twelve subjects. The price is \$25 for the 24. Additional prints only \$6 for the entire series, that is, 36 prints \$31, 48 prints \$37, etc.

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HOSPITAL MANAGEMENT

537 South Dearborn Street

Chicago, Illinois

England friends would insist that baked beans and brown bread belong to Saturday night. However, it would seem to me that brown bread and baked beans would sometimes taste better on any other day. What I have been trying to say is that getting out of the rut is the first step in successful and varied menu planning.

Another help would be to avoid the same food combinations, even though it is true that there are certain foods which either by preference of flavor or custom seem to actually belong to each other. The clever use of other combinations will conform to the rules of good menu planning and at the same time give a wider variety.

Again, did you ever think how much just a change in the shape of food materials seems to change the whole meal? For example, why should Waldorf salad always be cut in cubes? Why not cut the apples in long fingerlike pieces or even in balls and then prevent waste by using the scraps for sauce? Or on

the contrary, why does watermelon salad always have to be cut in balls? The same would apply to creamed potatoes. Because the time-honored recipe directed that they should be cut in small blocks; is there any reason why they should not take on other shapes? Even such a common, everyday food as bread becomes interesting when cut in a new shape. I leave you to apply this rule to all other foods.

In the third place, variety in menus is obtained often by a change in flavors. The addition of cheese, crumbs, condiments, and the like, will produce new flavors which will give zest to the too often jaded institutional appetite, leaving the impression that the meal has been very different.

In summarizing, then, let us remember that the element of surprise in menu planning expressed in new food combinations, new flavor combinations, and new methods of preparation as to shape and size will go a long way in producing variety in menus.

thinking. Men dig their graves with their teeth has become a slogan for every charlatan who wants to popularize some grotesque diet stimulated by misguided thinking or desire to commercialize some food product.

The conscientious physician and the dietetic department of a modern hospital strive to make use of those facts which experiment and experience have shown to be useful in the treatment of disease. They must also take a firm stand against fears and phobias which cultism has instilled in people's minds. Dietetics has indeed become the hand-maiden of rational therapeutics and the dietitian a necessary co-worker with the physician.

It is not my purpose to talk of the dietetic treatment of specific diseases, but to call attention to the functions and advantages of a well ordered department of dietetics and to touch on at least one of the possible weaknesses.

It goes without saying that a competent dietitian and her assistants must be well trained in the chemistry of the foodstuffs, must know something, enough, about metabolic processes and must have some acquaintance with those diseases at least whose causes are nutritional in nature. Only such an individual can intelligently carry out the instructions of the physician in charge. But she must be more than this; she must be a human being. She must not be content to sit in her office and figure diets; she must be more than a computer. She must be a stylist in the serving of food if she would minister to a body, and often to a mind, diseased. She must have some contact with the patient, her patient, win his co-operation and, without too much didacticism, give him some idea of the aims to be attained. One visit from an intelligently diplomatic dietitian may do much to secure the complete co-operation of a patient who wonders why he is getting much food and no medicine.

The department of dietetics is fulfilling a useful purpose in teaching the student nurse something about dietary treatment of disease. She learns not only the preparing and serving of special diets, but a modicum about the indications for such diets and the way in which they may be expected to accomplish their purpose, the cure, or at least the improvement of the patient and his illness.

The weakness to which I referred above is the tendency in modern hospitals to too complete standardization of diets. Diet lists probably serve a

The Chief of Staff Looks at the Dietary Department

By LLEWELLYN SALE, M. D.

President, Medical Staff, Jewish Hospital, St. Louis, Mo.

HARROP, in his excellent book, "Diet in Disease," quotes Oliver Wendell Holmes as follows: "I can not help believing that medical curative treatment will by and by resolve itself in a great measure into modifications of food swallowed. The effect of milk and vegetable diet, of cod liver oil, are only hints of what will be accomplished when we have learned to discover what organic elements are deficient or in excess in a case of chronic disease and the best way of correcting the abnormal condition" (1861, Medical Essays).

Stefansson in "The Friendly Arctic," says, "There is probably no field of human thought in which sentiment and prejudice take the place of judgment and logical thinking as completely as in dietetics."

Oliver Wendell Holmes was correct in his prophecy. Diet has become more and more important in the treatment of disordered bodily function. The present day physician is interested in reducing a high blood sugar, in stimulating a sluggish bone marrow, in supplying calcium to an organism deficient in this metal, in furnishing protein to a patient who

is losing too much albumen, in giving vitamins to an undernourished patient with a psychosis and a dermatitis. This he does by regulating his diet by including in it food and foodstuffs that will bring about the desired alchemy, rather than by prescribing nauseous drafts of medicine.

Stefansson, too, was right, and the pendulum has swung too far. Fads, fancies and cults have sprung up and sentiment and prejudice have taken the place of judgment and logical

This concise and direct presentation of the relationships between the physician and the dietitian and the place of diet in service to the sick opened one of the sections of the highly enjoyable round table in the gymnasium of Jewish Hospital, St. Louis, during the 1932 hospital conference of the American College of Surgeons.

useful purpose, but in them lies the inherent danger of reducing the practice of medicine to a rule of thumb. A traditional routine is followed and the individual needs and peculiarities of the patient are neglected. Any attempt to introduce into the practice of medicine in any of its phases too much of the spirit of the modern factory is fraught with danger. Diets, like paints, must be mixed with brains and also with human sympathy and understanding.

Many Factors in Food Costs

"That's mighty good coffee you're serving," a visiting superintendent told the executive of another hospital at the luncheon table recently, and the host explained that the coffee was made by the drip method.

"Do you serve coffee that way all through the house?" was asked.

"Yes," was the reply, "we have a student dietitian in each floor kitchen and she is responsible for the serving of coffee as well as other matters relating to the food service. We have drip equipment in each floor kitchen."

"But what about breakage? Isn't that expensive?"

"The dietitian is held responsible for breakage in her kitchen; that is, she must report as to the person causing the breakage, and whenever possible the offender is asked to pay for replacing the broken supplies or equipment, dishes, etc."

"Well, you fellows in these big hospitals might be able to afford a setup like that, but we little fellows can't do it."

This incident shows only one of the many factors which enter into meal costs and which make it futile to attempt to compare such costs simply on the basis of the figures given. The person attempting to make a comparison must know a great deal about the food service organization and many other features of both hospitals before he can say that one meal cost is too high or too low, etc.

"PSYLLIUM SEED"

"Psyllium Seed" is the title of a book by Dr. J. F. Montague, Montague Hospital, New York, in which the author endeavors to present all existing information concerning this laxative. It deals in a detailed way with various aspects of the subject, describing the seed and its properties.



Serving meals to patients in semi-private pavilion, Mt. Sinai Hospital, New York. View in floor pantry.

Features of Private Service of Mt. Sinai Hospital

In the 1930 report of the committee on dietetics, mention was made of the plan of bringing the private pavilion kitchen under the direction of the hospital's supervising dietitian, Miss Wood. It is of interest to report at this time that the change was most beneficial in every way. It resulted in a more efficient distribution of employes and also a correlation of the menus throughout the entire hospital, thus doing away with any waste there may have been in planning menus for an entirely separate unit.

For several years the committee had been desirous of introducing a new plan for serving the food in the private pavilion, which after careful study has been introduced without any additional expense to the hospital. Formerly the private pavilion

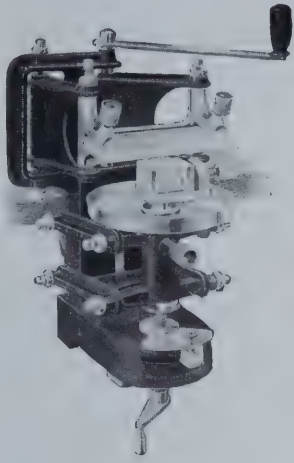
menus were made up with very little choice to suit the tastes of the individual. There were many requests for "special" food at each meal which could not be ignored and which were most difficult to handle. Now from the wide choice of food, which practically amounts to an "a la carte" service, both the very sick and the convalescent patient is able to make a selection which will appeal to him.

In December the new semi-private pavilion was opened. The food served to these patients has been of the same quality as that provided in the private pavilion, but not so wide a choice has been given as to the full paying private pavilion patients. The food for the new pavilion is prepared in the main kitchen of the hospital and transferred by means of electrically heated trucks to the respective floor pantries, the nurse in charge serving it directly from the trucks to the patients' trays.—Gladys Guggenheim Straus, Chairman, Committee on Dietetics, in annual report of Mt. Sinai Hospital, New York.

INSURES EMPLOYES

Fifty employes of the Bay Ridge Sanitarium, Inc., Brooklyn, N. Y., have been covered with life insurance protection in amounts ranging from \$500 to \$1,500, according to rank, through a group policy recently taken out by that institution. The Prudential Insurance Company of America issued the policy totalling \$45,500 and it is of the contributory type, the employes paying a part of the premiums and the Sanitarium assuming the remainder.



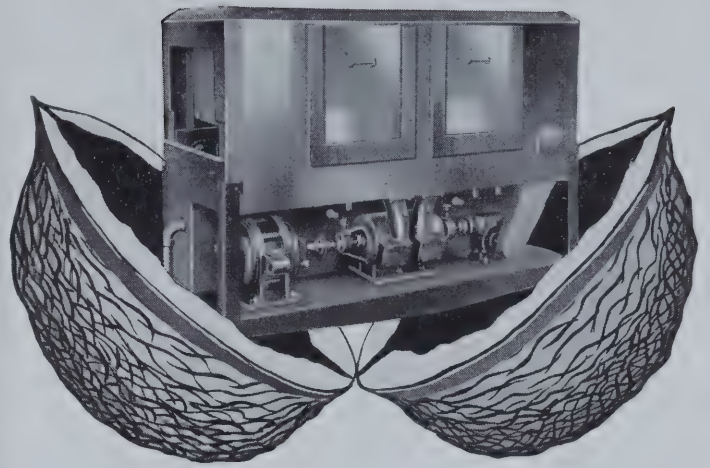


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Hot Food is Hospitals' Major Problem

By MARY HARRINGTON

Director of Dietetics, Harper Hospital, Detroit; 1932 Secretary, Dietetic Section, A. H. A.

THE dietetic section of the American Hospital Association felt that its chief function was to determine the problems of the dietary department which were of greatest concern to hospital superintendents. Knowing of no better way of undertaking this study, the questionnaire method was used.

The questionnaire was sent to 295 hospitals, selected from all parts of the country and with a minimum average of 125 beds. Only 47.2 per cent of the questionnaires were answered, showing the unpopularity of such a method of study.

In order to make a fairer comparison of answers, the hospitals were grouped according to the size as follows:

Group 1, hospitals averaging 125 beds; group 2, 175 beds; group 3, 225 beds; group 4, over 400 beds.

(1) The smaller hospitals assigned the responsibility of purchasing the food to the dietitians to a large extent, but Group 4 centralized all buying under a purchasing agent.

(2) Over 70 per cent of the dietitians in these hospitals made a contact with the patient, but in the smaller hospitals a visit was made only at the request of the physician or supervisor.

(3) Practically every hospital emphasized the splendid spirit of co-operation between the dietitian and the department heads.

(4) The major problem in the dietary department was the inability to serve food hot. Dish breakage ranked second in concern, and variety in the menus was third. All hospitals emphasized that food costs was one of the many factors in the budget that must be closely controlled at this time.

These problems are vitally important to dietitians, and the American Dietetic Association has undertaken studies to help solve them. For several years, studies have been made on the problem of hot food and various types of heated conveyors; central service and length of time food has been in transport from kitchen to the patient have been emphasized.

Dish breakage and loss are expensive problems common to all institu-

tions which the administrative section of the American Dietetic Association is studying and which shall be reported within the coming year.

Food costs of various types of institutions would be more valuable if a standard method of computing and analyzing them were adopted. An analysis of the amount of standard foods used per capita might be of more direct value in computing raw food costs, and the administration section of the American Dietetic Association will report on this study in the near future.

Sight Affected By Diet

Faulty diet may lead to serious eye maladies, reports Dr. Park Lewis, of Buffalo, N. Y., vice-president of the National Society for the Prevention of Blindness, discussing "Nutrition in Relation to the Eyes," in the current issue of the Society's quarterly journal, "The Sight-Saving Review."

The absence of vitamin A from the diet, for instance, causes "night blindness," which is manifested by a difficulty in seeing under faint illumination, as in twilight. This is only one of a number of different eye conditions that result from diet deficiency.

"It has been only during the last quarter of a century," says Dr. Lewis, "that the researches of a number of investigators, many of them American, have explained the principles of the historic dietetic procedures, such as the feeding of liver in night blindness or the use of fresh vegetables and citrus fruits in the treatment of scurvy."

"Vitamin A is of special importance because it has to do with changes occurring in the eyes. It



From a paper before 1932 A. H. A. dietetic section.

Hot Food, Breakage, Menus Big Problem

Here are the most troublesome problems in hospital food service, according to this study which was made by the dietetic section of the American Hospital Association:

1. Inability to serve food hot.
2. Dish breakage.
3. Obtaining variety in menus.

Any hospital which is satisfied that its food is served hot, therefore, is in an exceptional position, according to this study, which indicated that failure to serve food hot was the major problem among hospitals. In like manner, the hospital which has evolved a practical and self-perpetuating system of minimizing dish breakage ought to congratulate itself. As far as obtaining variety in menus, note the suggestions on page 48.

HOSPITAL MANAGEMENT will be glad to publish any suggestions from readers as to how they have met the difficulties discussed in this summary.

has been known for ages that certain conditions of malnutrition had an effect upon eye changes, and as long ago as the time of Hippocrates the use of liver was recommended for night blindness. Livingstone, when exploring in Africa, related that when his party was obliged for a time to live on roots and meal, there developed an affection of the eyes like that found in the case of animals limited to a starchy diet.

"This condition has recently been well understood and found due to the absence of vitamin A in the diet. In an institution in Copenhagen the young children were divided into two groups; one group received milk, a plentiful source of vitamin A, and the other received fat or vegetable fat in margarine, lacking in this essential. In eight cases among those on the vegetable diet, xerosis developed and was subsequently relieved by cod liver oil. On the other hand, in the group given whole milk, no disturbances occurred.

"The late Dr. James A. Stucky, who was very familiar with the conditions of the mountaineers in Kentucky and Tennessee, was of the opinion that many diseased conditions of the eyes in those sections were caused by malnutrition."

COLUMBUS HOUSEKEEPERS

In a three-reel film, filled with thrills, laughs and tears, featuring "Romance of Madge Morgan," the Columbus, O., chapter, National Executive Housekeepers Association, recently was entertained at White Cross Hospital, with Mrs. Nan McCloud as hostess. Mrs. Rhea J. Newquist, president, presided.

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The Record Department

When A. H. A. Discussed Records for First Time

THE earliest printed transactions of the American Hospital Association show that the word "records" appeared for the very first time in the proceedings of the convention of 1902, just 30 years ago. At that convention there was considerable discussion of records, which was hooked up with a discussion of statistical and financial records. One of the complaints was that there was no uniformity in methods of recording, no use of trying to compare records, and there wasn't even a single type of person in charge of histories and patients' records. As one man said, some hospitals in those days left the records in charge of clerks, others in charge of younger doctors, and others in charge of registrars, each of whom, apparently, wrote what he pleased and as he pleased. In fact, another complaint of the 1902 discussion on records was that some hospitals didn't count as admissions or deaths patients who died in the hospital 24 hours after admission. This complainant thought that there ought to be some uniformity about this, too.

One of the most interesting statements in the discussion referred to was that failure to obtain good records was not due to lack of interest or activity on the part of the younger medical man, but it was due to the inactivity and indifference of the older doctor who was supposed to supervise the proper recording of the information, and who also was supposed to complete the record.

It will be of interest to learn that at this convention 30 years ago one visitor had been told that all hospital problems were solved and that it was not necessary to have any associations or further conventions.

There is no question about the improvement of records since 1902 and 1903. For instance, at that time one well informed superintendent asserted that two-thirds of the patients' records were valueless because there was "no proper enforcement of careful, systematic and thorough-going history-taking."

Another superintendent said that the way to get good records was for every hospital to have a doctor, experienced in record work, in charge of this department, and when this speaker sat down, another equally prominent man arose and said that his department was organized in that way, but that there was difficulty in getting good records, nevertheless.

An insight into the methods of filing records in effect in 1902 was given by a man who described the system in his hospital. Here, it seems, the patient's history and other material making up the record was written on separate sheets, which were kept loose in a box. The objection to this method was that frequently when a doctor took out some of the sheets to read, he absent-mindedly put them into his pocket and never brought them back. The solution offered was that the history sheets be too large to be stuck into a pocket.

Another insight into the record departments of 30 years ago is thus given: The youngest doctor was made responsible for the writing of patient's notes. These

notes were written in a small book and carried in the doctor's pocket. Eventually the young man was supposed to copy them into the permanent records. However, the notes, frequently illegible in the beginning, became more illegible after being carried around, and even when the doctor did not carry the notes away permanently when he left, they frequently could not be deciphered for copying into the permanent records. Again, the book was frequently lost.

A solution of the problem of good records that undoubtedly has been voiced many times since was offered in 1903—a committee on records of the medical staff.

I hope that these rambling remarks are not a total loss as far as the program committee is concerned, for they will show that the work of handling records of patients has been materially improved since the early days of the American Hospital Association. The great bulk of the improvement, I believe, has come within the past ten years, during which time record librarians became class conscious. Within the past four or five years correspondingly greater improvement and smoothness has come into many record departments, because, through your association, so many record librarians have become acquainted with co-workers in other hospitals and have thus been able to exchange ideas and suggestions.

The association deserves a great deal of credit for making possible these exchanges of information and ideas which have removed or minimized difficulties in many hospital record departments. If this were the only accomplishment of the association its organization would be well worth while. But the Association of Record Librarians of North America is doing much more. It is beginning to set standards and to determine policies, and in this way it will prove of even greater help to the record librarians because it will give the record librarians backing and support in their efforts to introduce improvements and new methods into their own institutions. The recognition that the association has received from the different associations in the hospital and allied fields will make the association's influence correspondingly greater, and thus we may expect that the progress in many individual hospital record departments will be even more rapid in the future than in the immediate past.

In closing I will say that I think it is good to stop for a few minutes, especially in times like these, to look back and see that actual progress has been made, and that even in the hospital, which we today might regard as impossible from the standpoint of a well managed record department, in that department the records are immeasurably better than in some of the very best hospitals of 30 years ago. The greatest measure of this progress and improvement has been made possible through personal contacts, through exchange of ideas and information. With such a flourishing and highly successful association, and with an increasing number of local, state and other chapters coming into existence, the future of hospital records, generally speaking, and the progress of individual hospital record departments leaves nothing to be desired.

LOUISVILLE CHAPTER

President, Anne E. Moriarty, Jewish Hospital; vice-president, Mary C. Hubbuch, St. Joseph's Infirmary; secretary-treasurer, Carrie B. Williams, Norton Infirmary.

The foregoing are the officers of the recently organized Louisville, Ky., chapter of record librarians.

From remarks at 1932 convention, Association of Record Librarians of North America.



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Record Librarians Push Training Plans

FOLLOWING up the adoption of resolutions and reports setting forth the policies to be pursued in regard to training courses for record librarians, the Association of Record Librarians of North America is giving special attention to training plans, according to word from some of the officers.

Jessie Harned, record librarian, Rochester, N. Y., General Hospital, is chairman of a special committee on the training of record librarians and will be glad to communicate with hospital executives or record librarians interested in getting full details of the association's plans for courses.

Chairman Harned calls special attention to the following resolutions which were adopted at the 1932 convention:

"That in whatever hospitals there now exist classes for the training of record librarians, the curriculum shall be submitted to the executive committee of this Association for examination and approval as corresponding in principle with the 'educational course' suggested by this Association at its meeting in 1931, and approved by the Committee on Clinical Records of the American Hospital Association in 1932 (see Bulletin 100 of the American Hospital Association) and that it shall include instruction in elementary anatomy; that in the event of classes being organized in hospitals *other* than the above, the curriculum for training shall be based upon these same principles, and be submitted to the executive committee of this Association for approval.

"That graduates of training classes for record librarians conducted elsewhere than in hospitals of 200 beds or more, not approved by the American College of Surgeons, shall not be recognized by this Association.

"That copies of these two resolutions be sent to such hospitals as are conducting courses in the training of record librarians, and that they be published in early issues of the bulletins of the Association of Record Librarians of North America, the American College of Surgeons, and the American Hospital Association."

There is widespread interest in the educational program of the Association owing to the fact that this program has been drawn up with the cooperation of other national associations actively interested in the hospital field. The curriculum and conditions for entrance were carefully drawn, with high ideals in mind.

STUDENT ILLNESS REDUCED

There was a total of 878 days of illness among the 166 students of the Christ Hospital, Cincinnati, school of nursing, according to the annual report for 1931, an average of 5.28 days per student nurse. In 1930 the average was 7.87 days. "A great deal of time has been given in physical examinations, medical and surgical advice and treatment," said the report.

RECORD LIBRARIANS' MEETING

The 1933 convention of the Association of Record Librarians of North America is to be held in Chicago in October, presumably at the time of the hospital conference of the American College of Surgeons which will begin October 8.

RETURNS TO COLUMBUS

Dr. R. S. Fidler, who previously was pathologist at White Cross Hospital, Columbus, and more recently was in charge of the laboratory at Springfield City Hospital, Springfield, O., recently returned to the Columbus institution.

NEW ULTRA-VIOLET LAMP

A new electric bulb, similar to a lighting bulb, that produces the safe ultra-violet health rays at low cost for domestic use, has just been announced by George Lewis, president of the Cosmos Corporation, Newark, N. J. Dr. Ernst S. Meyer, technical advisor of the company, who was the director of public health of the Rockefeller Foundation and conducted the child welfare investigation in New York City for the organization, discovered in his infant mortality studies a close relationship between the varying amounts of sunlight throughout the year and seasonal increases in illness.

"The use of light for benefiting the health is still in its infancy," Mr. Lewis said. "Scientists and technicians for years sought ways to have sunshine 'on tap' in the home at reasonable cost. This is now possible in conjunction with house lighting.

"The new lamp will make it possible for miners or those employed in factories to work under the same ultra-violet rays under which the farmer works in a sunny field."

The lamp fits into the standard light socket and operates on either a.c. or d.c. current. No additional apparatus or precautions are necessary in using them.

USEFUL, ORNAMENTAL

The Workrite Specialty Company, Milwaukee, announce a new electrical appliance known as the Workrite Electric Humidifier, a portable, electric, motorized fan circulating humidifier. It has the appearance of a beautiful vase. The body has a beautiful black crystallized finish, and the base and the grille are brilliantly chromium plated. Size is 13½ inches high by 11½ inches in diameter. Operates off any electric socket. An important feature of the device is the low cost of operation for the large amount of vaporized air circulated.

LABORATORY TECHNICIANS CHANGE

Ruth Koons, for three years laboratory technician at the Massillon City Hospital, recently was appointed to a similar position at the Citizens Hospital, Barberton, Ohio, succeeding John J. Carey who resigned to go to a clinic at Ottumwa, Iowa.

ADDS TO DISH WASHER MODELS

Makers of Colt Autosan Dishwashing Machines announce that their rack model line has been increased to seven models. This line now includes rack models capable of washing all tableware for small institutions as well as the largest. Four new models have been added, all equipped with mechanical features to reduce dishwashing costs, at the same time guaranteeing thorough washing and complete efficiency.

THERMOMETER, RUBBER STANDARDS

The U. S. Department of Commerce, bureau of standards, has published a booklet on standards for clinical thermometers, containing a detailed description of the standards and a list of hospitals and other organizations which have agreed to accept these standards. A similar booklet on hospital rubber sheeting has been published. Representatives of the American Hospital Association are included in the committees which have helped to develop these standards.

BRIGHTER, CLEANER INSTRUMENTS

Wilmot Castle Company, Rochester, N. Y., announce the development of a preparation which will make it easier to keep instruments bright and untarnished and which will simplify the daily cleaning of sterilizers. The preparation is in the form of a tablet, one tablet to be used with each quart of water in the sterilizer. The tablets come in bottles of 100 and in jars of 500 and 1,000.

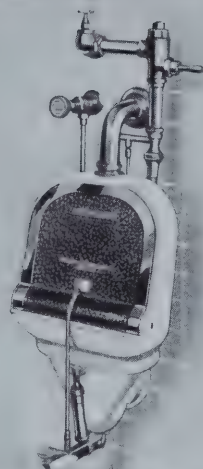
IMPROVED WATER BOTTLE

Classified as the ideal all-purpose water bottle, the Miller Rubber Products Company, Akron, announces introduction of its new No. 48 "Heatiator" which has passed exhaustive tests in the company's laboratories. Produced with inner walls which divide the bottle into compartments, it retains its flat surfaced shape when filled, thus utilizing every inch of heating area. Manufactured by the Anode process, the bottle is of lustrous black rubber with a satin smooth surface, soft and pliable, yet durable, and subject to little deterioration. Water capacity is more than two quarts and heating area in excess of 150 square inches, nearly three times that in the ordinary bottle.

The new bottle is especially adapted for use on all parts of the body, but is ideal for abdominal, chest and spinal application, and can be doubled around an ailing shoulder or wrapped around a knee, leg or arm.

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The busy trustee, conscious of his or her responsibility as a member of a hospital board, and compelled to get facts in the shortest time will find "Hospital Management" interesting and helpful.

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The Nursing Department

Here Are Instructions for Making Bed

The instructions below are for students of the school of nursing of Columbia Hospital, Milwaukee, Wis., Earl R. Chandler, hospital superintendent, and are based on long study of routine in Massachusetts General; St. Luke's, New York; Johns Hopkins; Presbyterian, Chicago, and other hospitals. Other instructions in this school which relate closely to hospital economics will be published in later issues.

EQUIPMENT—Mattress pad; 3 cotton sheets, upper, lower and draw; 1 rubber draw sheet; woolen blankets; spread; 2 pillow cases; 2 towels, bath and face; wash cloth.

DAILY PREPARATION—Sheet, pillow case, towels, wash cloth, whisk broom.

ORDER IN BED MAKING—(1) stripping bed, (2) making first side, (3) making second side, (4) general adjustment of bedside and room.

PRELIMINARY DETAILS

Have everything ready at bedside, amount of linen proportionate to number of beds to be made (one towel, one sheet, and one pillow case used daily for each bed) and whisk broom. Use top sheet of previous day for fresh draw sheet, unless it is soiled. A fresh under sheet is put on twice a week unless required oftener; a fresh spread once in four days.

Use careful judgment about changing linen and err on the economical side.

Arrange linen on stand, and move stand and chair away from bed.

STRIPPING BED

Note pillow cases and remove the one most soiled by firmly grasping end of pillow with left hand and stripping case from pillow with right. Place at head of bed for reception of soiled linen.

Place pillow on chair.

Loosen bed clothing by slightly lifting edge of mattress with one hand and slip out clothing with other.

Fold spread and place on head of bed.

Remove each blanket separately, fold and hang on back of chair; likewise the sheets if not soiled.

If soiled, the draw sheet is gathered up, keeping the dust inside, and placed in pillow case.

Brush rubber draw sheet, remove and place on chair. Remove lower sheet.

Brush off mattress around buttons and bindings, sweeping from edge to edge.

Turn mattress from head to foot to shift the wear and position, the greatest pressure being nearer the head of the bed. If the mattress becomes flattened on one side more than the other, it is permissible to turn it from side to side occasionally. See that the mattress is even with the foot of the bed before starting to make the bed.

MAKING FIRST SIDE OF BED

Place sheet on bed with folded crease in middle. Carry over at top and extend six inches under mattress. Make corner and tuck sheet along side under mattress. At foot pull tightly and tuck under mattress. Make corner and complete tucking in at side.

See that rubber sheet is whole. Place it on the bed so that it extends well under the pillow. Allow two inches for extra tension on the opposite side when that shall be drawn tight. Tuck snugly under mattress.

Fold upper sheet for draw sheet by bringing hems together, then folding in fan fashion with selvedge edges toward center, ready to be placed in position on bed. Place on side of bed with selvedge edges toward middle of bed and two inches above top of rubber sheet. Turn down the upper fold and tuck securely under the mattress.

Place upper sheet on bed, hem wrong side up, the edge six inches from head of mattress after turning a twelve-inch fold under itself, temporarily out of the way. Tuck bottom of sheet under mattress half way across the foot of bed. Make corner and tuck in along side.

Put on first blanket even with fold of upper sheet, i.e., six inches from head of mattress, which gives the patient sufficient covering for his shoulders when lying on his side. If blankets are short, the last blanket should be put on the bed about eight or ten inches lower than the others, in order to cover patient's feet and to hold bed clothing in position. The two blankets are tucked under mattress separately, half way across foot of bed. Make corner and tuck under mattress along side.

MAKING SECOND SIDE OF BED

Step to opposite side. Pick up hanging rubber sheet at side of bed and bed clothes with it. Fold back neatly, exposing half of bed and under sheet.

Lift mattress at head and tuck in remainder of sheet; make corner. At foot of bed, grasp sheet with one hand, raise mattress with the other to get tension, and tuck under firmly; make corner.

Step to side of bed, grasp sheet firmly in the center, with palms of hand downward, right knee braced against bed to steady it, and pull with an upward swing on the hands. This serves as a check and prevents the sheet from being pulled out on the opposite side. Tuck under mattress while the sheet is at extreme tension.

Grasp edge of rubber sheet in middle. Pull tightly and carry to full extent under mattress. The same procedure is carried out with the cotton draw sheet.

Adjust upper sheet and tuck under mattress at foot. Make corner and tuck in along side. Carry out same procedure with blankets. Bring top of sheet out over blankets and tuck in.

Step back to first side, turn top of sheet out over blankets and tuck in.

Place spread on bed evenly. Tuck under mattress at foot. Make envelope corner.

PILLOWS

Adjustment of first pillow (case not changed).

Grasp the long-seam side and settle the pillow toward the opposite side of case. Place pillow on table and smooth firmly from end to end. Reverse pillow and repeat process. Grasp seam side of case with both hands and place carefully on bed with open end away from door.

Adjustment of second pillow (case changed).

A fresh case is put on by holding pillow between left elbow and side while both hands are employed in opening the clean case, in which the end of pillow is inserted and the pillow shaken down into the corners.

As the case is usually larger than the pillow, grasp

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HOSPITAL SALES DEPARTMENT

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the long-seam side of case and settle pillow toward the seamless side, when it is treated in the same manner as the first pillow and put in position over first pillow.

Note: It is not usually necessary to change more than one pillow case daily and that only if soiled or damp with perspiration.

GENERAL ADJUSTMENT OF BEDSIDE AND ROOM

Bedside table should be parallel with head of bed. Inspect drawer for concealed food, drugs, etc., as it is solely for small and necessary effects of patient, i.e., comb and other toilet articles. *Wash top of table.*

Place chair beside foot of bed.

Scrutinize your work and do not leave until everything is in order.

NOTES

If uninterrupted, one should not need more than five to eight minutes to make an empty bed.

Stains—Blood stained pillows and mattresses are excusable in a well equipped hospital ward where rubber pillow cases are provided and rubber sheets kept in good repair. The same may be said of unsightly stains on bed linen due to the use of silver solutions, gumming tinctures, ointments, and disinfectants. Method of handling soiled linen—In transportation of clean linen from one bedside to another it should not come in contact with any bedding other than that of the bed for which it is intended.

The soiled linen, on removal from bed, should be put into pillow case at once. Enough cannot be said against throwing soiled bed linen on the floor during the bed making. It means danger of scattering of bed dust and germs. It means handling the linen twice. It denotes slovenly and disorderly methods.

Does Your School Have Its School Paper?

A NUMBER of schools of nursing recently began publication of their own school papers. News of alumnae, of class activities, social events, changes among faculty, and the many interesting news items which are available in most schools have added interest when they are set down in printer's ink in a little paper bearing the seal of the school or a name that serves to bind students, faculty and alumnae closer together.

Some of the schools which recently began to publish their own papers have suggested that it would be nice to exchange copies with papers published by other schools. To help as many schools as possible that wish to do this, HOSPITAL MANAGEMENT publishes below some of the schools in the Middle West and elsewhere which have their own papers:

"Our Chart," Georgia Baptist Hospital, Atlanta, Ga.

"Murphy Echo," John B. Murphy School of Nursing, Chicago.

"Semper Fidelis," St. Joseph School of Nursing, Chicago.

"Mercy Hospital Bulletin," Mercy School of Nursing, Bay City, Mich.

"St. John's Echo," St. John's School of Nursing, Springfield, Ill.

"The Tie," St. John's School of Nursing, St. Louis, Mo.

"The Torch" (semi-annual), South Side Hospital School of Nursing, Pittsburgh, Pa.

HOSPITAL MANAGEMENT will be very glad to publish names of other schools with papers if they are sent to the editor. In the meantime, directors of schools which de-

sire to exchange papers with any of the foregoing schools should communicate with them.

HOSPITAL MANAGEMENT will be very glad to receive copies of nursing school papers, which frequently contain items of general interest as well as material of greatest concern to the individual student body.

A HOUSEKEEPING REPORT

"The housekeeping department has the care of the physical condition and the appearance of fifteen separate buildings which are used to house the hospital and its personnel," says the report of Grace Hospital, New Haven, Conn. "One hundred ninety-four employes are housed on the premises, in addition to the patients, so you can see that this department has quite a job on its hands when you consider that it controls all of the cleaning services, and furnishes the necessary linen and other laundry supplies for the entire institution. Thirty-eight persons are required to carry on the work of this department, this being a reduction of three people since April, 1931, in spite of the fact that we have opened a new dormitory and the work in the laundry has largely increased during the past year.

"There has been a reduction of \$7,000 per annum in the operating cost of this department. This has been brought about by a more economical use of supplies, a better allocation of time among the employes, the elimination of overtime in the laundry and elsewhere. The work in the laundry has been simplified by a relocation of the machinery therein and the installation of a six roll flat work ironer, a drying tumbler, three automatic steam presses and two new electric hand irons. The work in the laundry has increased from about three thousand pounds per day last year to approximately four thousand pounds per day during 1931.

"A new dormitory was opened for graduate nurses and the furnishing of this house was handled by the housekeeping department. The furnishings for this residence were purchased with the idea that when a new nurse's dormitory is built these furnishings will be available. About four hundred yards of curtain and upholstering material were used in the department, during the past year; six new dressers were purchased and fifteen new chairs; all of which replaced old ones which were beyond repair. All of the furniture in the entire institution has been repaired when necessary. One waxing machine has been added, for the maintenance of floors and a new commercial type sewing machine was purchased to replace a worn out domestic type."

EXTRACTS PINEAPPLE JUICE

A device has been perfected to extract juice from pineapples as easily and simply as though squeezing an orange. Pineapple has always been recognized as a delicious and healthful fruit, but its juice has never been exploited commercially like other fruit juices, due to the great difficulty in extracting it from the fresh fruit. The "Unity" Pineapple Juice Extractor, recently brought on the market by Albert Pick-Barth Company, Inc., Chicago, is the device. It extracts juice from the pineapple, quickly and simply. The pineapple is simply cut in half horizontally—without peeling—and placed in the extractor. A few turns of the crank does all the work, leaving only the skin and the core. The extractor is so designed that the clear juice drops into a pan through a strainer which retains all the pulp. This pineapple pulp is delicious in itself and may be used for sundae topping, in ices or as a pastry filling. An adapter plug, furnished with each machine, quickly turns it into an extractor for grapefruit or other citrus fruits.

CHINA DURABILITY IMPORTANT

"Because every dollar must be made to count today, chinaware buyers in the hotel, club, restaurant and institutional field can no longer be sold merely because they happen to favor a particular pattern or design," says the D. E. McNicol Pottery Company. "Today the chinaware salesman must be prepared to answer plenty of questions. Even such technical factors as the process used in manufacturing the china are now familiar subjects to the china buyer who is out to get his money's worth.

"We don't claim to be prophets or fortune-tellers, but two years ago we decided that chinaware manufacturers were in for a long period of close-buying. And, although the cost ran into the hundreds of thousands of dollars, we ripped out every kiln we had and installed the newly-perfected tunnel-kiln process. As a result we have been delivering chinaware that is not only uniform in color and texture, but has already demonstrated that it will render years of service. Furthermore, we made it our business to glaze our china with the highest fire ever used in making vitrified hotel china. By doing this we were able to develop a super-durable glaze that minimizes scratching and chipping and reduces breakage."

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912

Of Hospital Management, published monthly at Chicago, Illinois, for October 1, 1932.

State of Illinois, County of Cook, ss.

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Matthew O. Foley, who, having been duly sworn according to law, deposes and says that he is the Editor of the Hospital Management and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Publisher, Crain Publishing Co. (a partnership), Chicago, Illinois; Editor, Matthew O. Foley, Chicago, Illinois; Managing Editor, None; Business Manager, Kenneth C. Crain, Chicago, Ill.

2. That the owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one per cent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.) Crain Publishing Co. (a partnership), 537 S. Dearborn St., Chicago, Ill.; Kenneth C. Crain, 537 S. Dearborn St., Chicago, Ill.; Matthew O. Foley, 537 S. Dearborn St., Chicago, Ill.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state). None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is..... (This information is required from daily publications only.)

(Signature) MATTHEW O. FOLEY.

Sworn to and subscribed before me this 26th day of September, 1932.

ELLEN KEBBY.

[SEAL]

(My commission expires Apr., 1935.)

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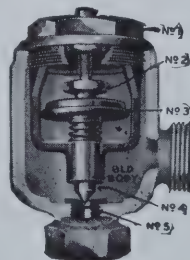
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The Laundry Department

What Enters Into Cost of Laundry Work?

By Walter E. List, M. D.

Superintendent Jewish Hospital, Cincinnati, O.

EVERY hospital superintendent is, or should be, interested in the operating cost of every department. In the construction and equipping of these departments, little or no thought is given as to how costs are to be determined. This is particularly true of the laundry department.

Most superintendents are contented to know the total of the labor costs, of the cost of the supplies used, and of the cost of repairs and replacements. If there is a scale, the cost per pound on these accounts may be obtained. There are, however, some superintendents who are not satisfied with such meager information and who demand more detailed and accurate cost figures.

To determine "exact" laundry costs, it is necessary to have the accurate cost of steam in addition to accurate labor costs and cost of supplies other than soaps, soda, starch, and padding. This must be obtained by exact accounting of the power plant to ascertain the cost of the steam produced. Then with a steam flow-meter on the lines supplying the laundry, a gas meter (if gas is used), an electric meter, and a water meter installed, it is an easy matter to obtain the cost of these items and include them in the total cost of the department. Most hospitals do not figure depreciation but consider replacements as such.

A floor scale large enough to hold a laundry truck should be provided and the net weight of the linens only should be taken into consideration, deducting 50 per cent of the weight when the linens are wet.

Many superintendents wish to know what it costs to launder an ether mask, a sheet, or a nurse's uniform. Merely to count the total number of pieces being laundered and divide the number into the total cost is not a very accurate method and is of little or no value. To secure accuracy on cost per piece entails a time study for each item on every step from the "wheel" to the "press." This procedure is extremely expensive and would be worthless unless a comparison could be made with some other institution which determines its costs in the same way.

The cost per pound is the most simple, inexpensive and satisfactory method to use for comparison among institutions.

The following is a monthly report of the laundry department of the Jewish Hospital and shows what the average institution is able to secure in costs figures.

LAUNDRY DEPARTMENT August, 1932

Expenses—	August, 1932	July, 1932	1932 to date
Salaries	\$2,264.49	\$2,391.48	\$20,129.10
Supplies	349.29	288.30	2,872.74
Repair and replacements		151.20	437.01
Total	\$2,613.78	\$2,830.98	\$23,438.85
Number of pounds ...	166,413	175,662	1,582,530
Cost per pound	\$0.0471	\$0.0441	\$0.0444
Supplies—			
6 bbls. Amber Flake Soap			\$ 64.20

6 bbls.	Yellow Hoop Soda	53.70
3 bbls.	Satin Finish Starch	57.18
6 cans	H. T. H. Bleach	9.00
6 rolls	90-inch Top Covering	194.40
9 pads	Scratch Paper .....	.18
6 pairs	Canvas Gloves	1.50
24 balls	Twine	1.80
24 rolls	Toilet paper	2.16
6 lbs.	Roach Doom	4.80
1	Pot Brush .....	.90
Total		\$399.00

LABORATORIES AND X-RAY DEPARTMENTS

The American Medical Association's 1932 compilation of hospital information shows that there were 4,233 laboratories in reputable hospitals in 1931, compared to 3,035 in 1923. This is an increase of 1,198 in eight years.

X-ray departments of hospitals in the same period grew from 2,841 to 4,615, a gain of 1,774.

REFRIGERATED CENTRIFUGE

Uses of a refrigerator centrifuge at Mt. Sinai Hospital, New York, according to Dr. Joseph Turner, director, are:

1. To separate chicken plasms from blood because the cool temperature prevents too rapid congestion of the blood.
2. In a centrifugalization of bacteria under conditions which will inhibit their growth while centrifugalization is going on, and finally,
3. In order to separate solid particles from protein matrix under those conditions where it is necessary to inhibit autolysis, fermentation or bacterial growth.

USEFUL SWITCH

A new, low-cost photoelectric relay, the Foto-Switch, is announced by G-M Laboratories, Inc., Chicago. This unit embodies an electro-magnetic switch which is opened or closed by the interruption or variation in the illumination on the photoelectric cell. With the switch, any sort of electrical device, such as motors, electric signs, signals, or alarms, can be controlled through the medium of a light beam.

The Foto-Switch is capable of handling many commercial applications which do not require the ruggedness demanded of industrial installations. Door-opening installations, automatic illumination control, burglar alarms, control of electrical displays in store windows, signals for customers entering stores, counting people or products, control of electric sign illumination, and many other uses are entirely within the range of this unit.

Full information on the Foto-Switch and available accessories can be obtained from G-M Laboratories, Inc.

THE HOSPITAL CALENDAR

Hospital Association of Pennsylvania, Philadelphia, March 21-23, 1933.

Mississippi Hospital Association and Mississippi State Medical Association, Jackson, April 10, 1933.

Iowa Hospital Association, Marshalltown, April 19-20, 1933.

Biennial meeting, national nursing organizations, Washington, D. C., April 22-27, 1934.

Illinois-Indiana-Wisconsin joint conference, Chicago, May 3-5, 1933.

South Dakota Hospital Association, Sioux Falls, 1933.

Western Hospital Association, Long Beach, Cal., 1933.

American Hospital Association, Milwaukee, Wis., September 11-15, 1933.

Association of Record Librarians of North America, Chicago, October 8-11, 1933.

American College of Surgeons, Chicago, October 8-11, 1933.

HOSPITAL MANAGEMENT for November, 1932

CLASSIFIED ADVERTISEMENTS

Use this department to secure employment, fill positions which are open, buy or sell commodities or service, etc., etc.

Rates are eight cents per word per insertion. If copy is repeated without change in three consecutive issues the total charge is twice the charge for a single insertion. Instructions to print classified advertisements should be accompanied by

check, money order, or cash in full payment.

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SURGICAL NURSES—(A) Privately owned small hospital located large northern city needs surgical nurse willing to act as Superintendent of Nurses. Ability to give anesthetics desirable. (B) Small hospital, southwest, seeks operating room nurse willing to relieve on general duty. No. 5080

NURSE-TECHNICIANS WANTED — (A) Northern church hospital (Protestant) wants nurse-laboratorian-Xray technician who knows or is willing to learn some physical therapy. Good salary. Proximity of college offers opportunity to work toward degree if desired. (B) Tennessee hospital wants Laboratorian, willing to relieve on floors. (C) Nurse-Laboratorian-Xray technician wanted, good-sized California hospital; state earliest reporting date and salary desired. (D) Nurse-Xray technician wanted, New York hospital; salary open. No. 5081

LABORATORIANS — (A) FACS located Pacific coast, wants woman Laboratory-Xray technician as office assistant. Interview required. Salary open. (B) Mature woman Laboratory-Xray technician wanted, small midwestern hospital; General Electric equipment. (C) Indian missionary hospital needs laboratorian; preferably woman able to give anesthetics. No. 5082

MISCELLANEOUS VACANCIES—(A) Large eastern hospital wants experienced social worker to manage department. Immediate vacancy. (B) West coast hospital wants instructor, willing to act as Anesthetist temporarily. (C) Superintendent, for approved northwestern hospital; training school averages 12; especially desirable quarters; full maintenance. State salary desired when applying. No. 5083 1132

The Medical Bureau is organized to assist physicians, dentists, graduate nurses, hospital executives, laboratory technicians and dietitians in securing positions; application on request. The Medical Bureau (M. Burneice Larson, Director), 3800 Pittsfield Bldg., Chicago. tf

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ASSISTANT PURCHASING AGENT—Young man would like position. Five years' experience in hospital supply business, three years on the road, acquiring good inside knowledge on quality, brands and costs. Well acquainted with purchasing department procedure and business management. Address Hospital Management, Box 508. 1132

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ANESTHETIST - SUPERINTENDENT — Trained Lakeside Hospital, Cleveland; available for appointment to southern hospital; over six years' experience as Chief Anesthetist; have installed ACS system of record-keeping; experienced as Supervisor and Superintendent; willing to combine Anesthesia with other work; will take Superintendency of small hospital if no training school. Address Hospital Management, Box 505. 1132

OBSTETRICAL SUPERVISOR AVAILABLE—Indiana registered nurse with post-graduate training in Obstetrics and 5 years of supervising obstetrical department in 150-bed hospital; available now. Good references. Will report for interview anywhere in central or eastern United States. Address Hospital Management, Box 506. 1132

COLLEGE GRADUATE — Registered nurse wants position as Assistant Superintendent and Instructor; 4 years' experience in similar work at 300-bed western hospital. Address Hospital Management, Box 507. 1132

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ASSISTANT SUPERINTENDENT OR INSTRUCTOR—Training includes B. A. degree; 3 years approved nursing school. Has had 4 years' nursing experience. Catholic. Age 30. Prefers west or southwest. Available now. No. 5087

SUPERINTENDENT OF NURSES — Has college degree; registered nurse with five and one-half years' experience teaching; Protestant; age 29; prefers east. No. 5088—1132

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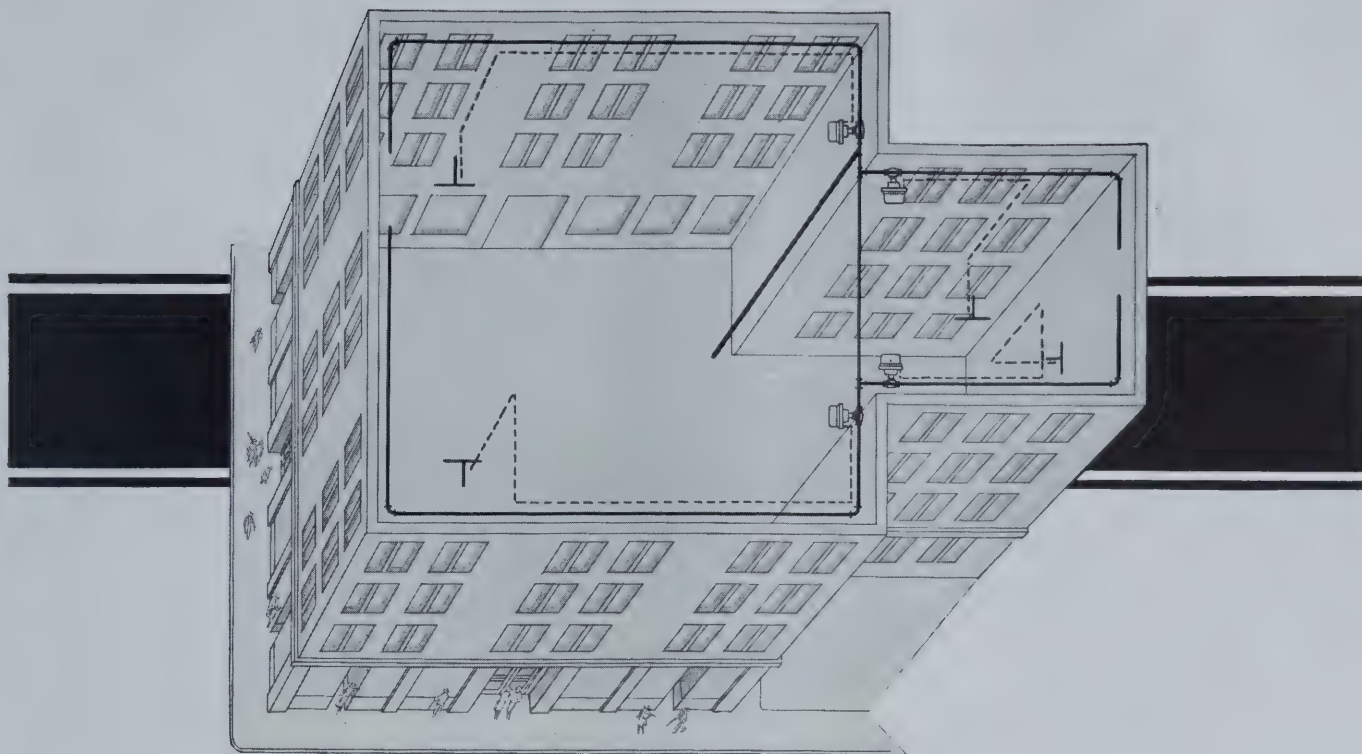
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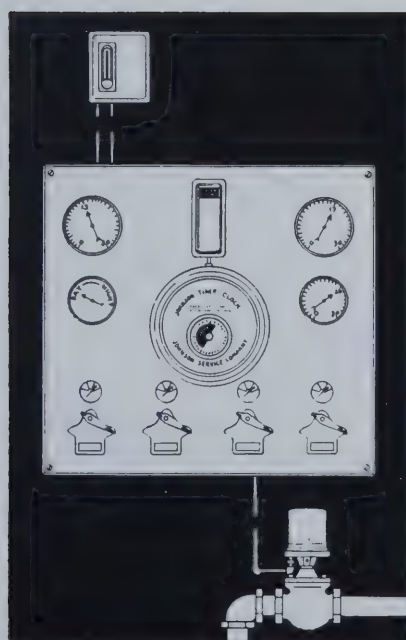
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This new edition has been entirely rewritten and much new material has been added. It discusses many departments, including the Kitchen and Laundry, devotes special chapters to Heating, Ventilation and Plumbing—Details of Construction and Finish Equipment—Landscape Architecture as applied to Hospitals, etc., etc.

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Send me copies of the new edition of The American Hospital of the Twentieth Century, at the special price of \$7.50 per copy. Payment is enclosed.

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AD-venturing

In thousands of hospitals, nurses' homes, schools, clubs, hotels, and homes this remarkable safety mixer is replacing ordinary mixing valves because it prevents sudden "shots" of cold or scalding water due to the use of nearby faucets, flush valves, etc. Page 69.

* * *

A drab time becomes a happy time—relaxation time—a short time, when a Western Electric Music Reproducing System entertains the convalescent. Getting well then becomes play. This system is serving many modern hospitals at an upkeep cost of only a few cents an hour. Patients in wards use individual headsets—those in private rooms use either headsets or loud speakers. Records are the source of the program. Page 1.

* * *

This new Adobe ware with its revolutionary new coloring might very easily have been the inspiration of some discouraged patient, weary of turning from all diets with disgust. For its warm and unusual coloring builds up the optic appeal of the most depressing foods—actually makes the most monotonous diets gaily appetizing. The fact that there is a direct connection between the appearance of a meal and the amount that is eaten is not news to you. But when you compare your present china, as many hospitals are doing, with this new Adobe ware you may realize for the first time just how important the china itself really is. Pages 58 and 59.

* * *

Your hospital's name printed on the wrappers with orders of 1,000 cakes or more. Mail coupon for our new free building cleanliness booklet and prices of Palmolive Soap in the five special sizes for hospitals. Page 68.

* * *

If you wish, we'll design a pattern for your exclusive use, as we have for hundreds of the finest hospitals, clubs, restaurants, cafeterias and hotels. Page 64.

* * *

Nearly three hundred years ago Jeanne Mance selected a site at the foot of Mount Royal on the island of Montreal and superintended the construction of a building of rough hewn timbers—the Hotel Dieu that was to serve as hospital to the little colony of Villemarie. On the same site today stands a modern and more

These pithy paragraphs of practical and pertinent information concerning supplies and equipment are typical of the kind of information manufacturers and sales organizations offer readers of "Hospital Management" in every issue. Experienced hospital executives make it a point to read advertising pages carefully, too, and to keep in touch with new ideas and improvements in equipment and supplies as well as in methods of hospital administration. Every issue contains information as interesting and helpful as the paragraphs on this page, chosen at random from this month's advertisements.

imposing Hotel Dieu—a monument to the determination and fearlessness of the gentlewoman who left wealth and comfort in France to face danger and privation in the wilderness of Canada. Page 67.

* * *

If you're open to conviction, and ready to be shown the bargain of bargains in towels, the best way to settle the question is to get a real, honest-to-goodness towel before you and put it to your own tests. Page 18.

* * *

Because the Victor Model "D" Mobile Unit is shock proof, no restrictions are imposed on the operator in his desire to obtain the best diagnostic view of the part under observation. There are no exposed high tension parts to be avoided, consequently the utmost flexibility is afforded in obtaining preferred position of the tube, irrespective of metal parts of the bed or other current conductors adjacent. In the operating room, too, this feature is important. Page 71.

* * *

It's not so difficult, after all, to make prunes—those familiar prunes—interesting to even the fussiest hospital appetites. You'll find that out when you serve the prune dishes shown on this page. Page 57.

* * *

A little patient tosses fretfully in her bed. Kept awake—kept back from health—by the unceasing clatter of footsteps on the noisy corridor floors. Such a hospital floor may be

"cured" of noisiness in less than twelve hours. Simply lay Sealex Linoleum right on top of the old-fashioned, racket-promoting floor. Then you have a floor that will never be a source of annoyance to a single patient. Sealex Linoleum is resilient. That's why it is quiet. Page 49.

* * *

One very good customer recently volunteered an enthusiastic description of the effect of a "home-like" china on the patients, and added, "We find practically no difference in breakage cost between our new ware and the plain service formerly used." Repeatedly, careful cost records from many other hospitals confirm this statement—prove that no hospital willing to dig deep enough into costs need be content with harsh, conventional, bulky china. Page 14.

* * *

Right at a time when all hospital expense is under close scrutiny—when rigid hospital economy is imperative—when a hospital dollar must stretch as never before—"Lysol" disinfectant comes through with a new phenol coefficient that cuts the cost of hospital disinfection to an absolute minimum—a "Lysol" twice as powerful with no increase in caustic properties—a "Lysol" twice as quick in dealing out death to germs. Page 11.

* * *

You know how patients feel about most corrective foods. They don't like them—and a good many times they won't eat them. That's why we believe you'll be particularly glad to know about Heinz Rice Flakes. For this cereal makes patients ask for second servings! Page 17.

* * *

At every stage in the production of Continental coffee, the skill born of specialization forms a barrier against inferiority, and assures a coffee pre-eminently suited to the needs of hospitals, clubs, and institutions. This famous blend produces a beverage which cheers and comforts the patient, and offers pleasurable refreshment to the staff. Page 65.

* * *

The quality and engineering perfection long associated with Ideal Food Conveyor Systems has been expanded to include hospital portable and surgical equipment. Page 55.

* * *

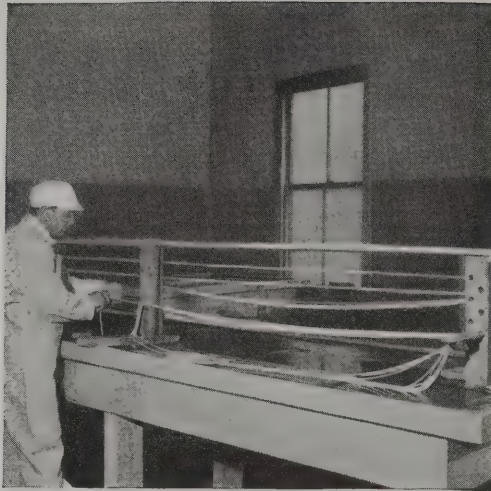
Your investment of thousands of dollars in dishes and silverware requires the protection of safe cleaning. Brown stains on dishes and tarnish on silverware can be avoided by the use of Wyandotte Cherokee Cleaner. Page 13.

RESEARCH

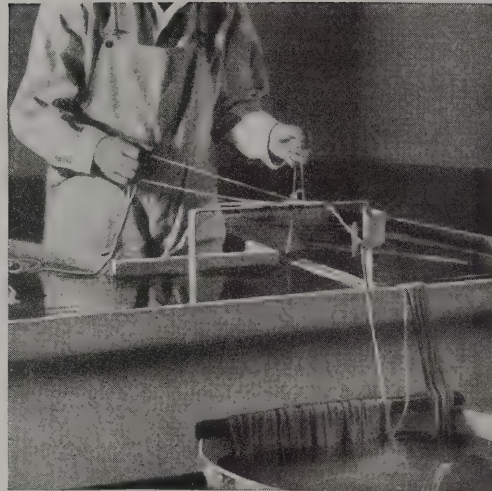
BACK OF *D&G Sutures*



OUR organization has always recognized the importance of sutures in surgery and the obligation of the manufacturer to the surgeon and to the patient. In the preparation of *D&G Sutures* we have sought the aid of chemists, bacteriologists, and surgeons of the first rank; and have spared neither effort nor expense in perfecting our products. From the inception of this business we have maintained a program of research activity, to the end that our service extend beyond the filling of existing demands and include the development of new methods and new materials of practical value to surgery.



SPINNING RAW CATGUT



SPLITTING CASINGS

Experimental Raw Catgut Laboratory

WE have established a fully equipped experimental gut string plant, in Brooklyn, entirely separate from our manu-

facturing laboratories and devoted exclusively to research problems relating to the preparation of raw catgut.

Bacteriologic Laboratory

IN our main plant we maintain a bacteriologic laboratory of the most modern construction. All work is conducted in dust-proof, plate glass chambers, supplied with filtered air and equipped with a system for spraying the interior with a germicidal solution. Every known safeguard is em-

ployed, and the personnel consists of bacteriologists who have had years of experience in testing surgical sutures. In this laboratory, sterility tests are conducted on each lot of sutures manufactured, and in addition research problems connected with the bacteriology of sutures are investigated.

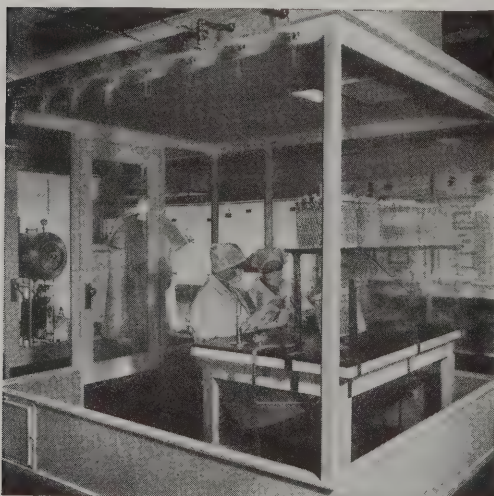


PLATE GLASS CHAMBER



TESTING SPECIMEN SUTURES



ANIMAL ROOM



OPERATING ROOM

Fellowship in Surgical Research

THE holder of the Davis & Geck Fellowship at the Yale University School of Medicine has at his disposal the necessary animal room and laboratory facilities, including the service of a trained technician, for investigating the behavior of sutures. A completely equipped operating room, to-

gether with a surgical laboratory, is available for experimental as well as clinical research. Here are studied the reactions of the tissues to sutures, the absorption time of catgut, and the action on the tissues of various chemical compounds with which sutures may be impregnated.

Research Chemical Laboratory

IN this laboratory, members of our staff are continually studying problems in the field of applied chemistry as related to sutures. Through the association with our

company of Allen Rogers, Ph. D., head of the Department of Chemical Engineering of Pratt Institute, the facilities of that department are also available to our staff.



RESEARCH CHEMICAL LABORATORY

CO-OPERATING with our research personnel is a consulting staff of surgeons and bacteriologists of national repute who, through their skill, knowledge, and intimate association with surgical problems, furnish practical and clinical data to supplement the laboratory findings. This background of research and scientific development has enabled our organization to maintain its leadership in the production of sterile surgical sutures. We will not, however, rest content with what has been accomplished thus far. Surgeons and hospitals may be assured that Davis & Geck products will at all times represent the highest development in the suture field.

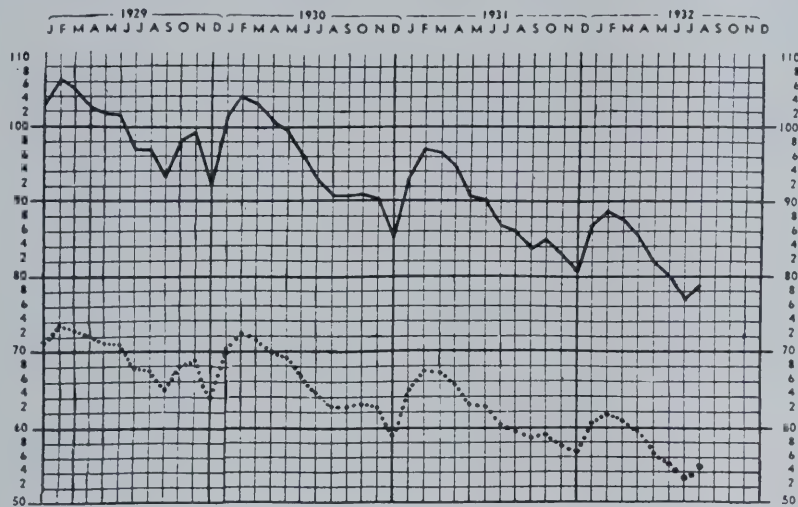


DAVIS & GECK, INC. ♡ 217 DUFFIELD ST. ♡ BROOKLYN, N. Y.

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HOW'S BUSINESS?

A composite picture of the percentage of occupancy in 91 general hospitals located in 87 communities in 35 states, corrected for normal growth.



The heavy line shows the occupancy of hospitals, based on the average occupancy of 1929 as 100 per cent. The dotted line shows the actual occupancy, based on the total bed capacity of the hospitals participating in this monthly survey.

Here Are Figures From Which Occupancy Chart Was Constructed

THE following figures are the basis of the hospital occupancy chart reproduced at the top of this page. These figures were supplied by 91 general hospitals in 87 communities of 35 states, with a basic bed capacity of 16,922.

The first group of figures represents actual number of beds occupied; the second group, receipts from patients; the third, operating expenses of the hospitals for each month since the "How's Business" graphs were begun, and the fourth, occupancy, using 100 per cent as the base.

TOTAL DAILY AVERAGE PATIENT CENSUS

November, 1928	11,533
December, 1928	11,040
January, 1929	11,919
February, 1929	12,335
March, 1929	12,253
April, 1929	12,114
May, 1929	11,981
June, 1929	12,025
July, 1929	11,473
August, 1929	11,548
September, 1929	11,157
October, 1929	11,590
November, 1929	11,736
December, 1929	10,977
January, 1930	12,048
February, 1930	12,425
March, 1930	12,408
April, 1930	12,128
May, 1930	12,044
June, 1930	11,601
July, 1930	11,290
August, 1930	10,997
September, 1930	11,015
October, 1930	11,086
November, 1930	11,005
December, 1930	10,524

January, 1931	11,510
February, 1931	11,991
March, 1931	11,970
April, 1931	11,669
May, 1931	11,251
June, 1931	11,187
July, 1931	10,765
August, 1931	10,657
September, 1931	10,409
October, 1931	10,499
November, 1931	10,266
December, 1931	10,145
January, 1932	10,758
February, 1932	11,038
March, 1932	10,888
April, 1932	10,596
May, 1932	10,082
June, 1932	9,927
July, 1932	9,571
August, 1932	9,748

RECEIPTS FROM PATIENTS

November, 1928	\$1,678,735.00
December, 1928	1,736,302.86
January, 1929	1,795,843.79
February, 1929	1,776,040.82
March, 1929	2,024,823.11
April, 1929	1,929,175.70
May, 1929	1,920,982.43
June, 1929	1,874,173.11
July, 1929	1,846,899.32
August, 1929	1,867,706.24
September, 1929	1,772,230.39
October, 1929	1,828,051.39
November, 1929	1,786,036.71
December, 1929	1,737,404.65
January, 1930	1,840,418.05
February, 1930	1,799,080.00
March, 1930	2,003,309.58
April, 1930	1,927,493.30
May, 1930	1,921,523.05
June, 1930	1,817,813.00
July, 1930	1,803,315.00
August, 1930	1,719,634.00
September, 1930	1,700,314.00
October, 1930	1,741,017.00
November, 1930	1,640,374.00
December, 1930	1,687,813.00
January, 1931	1,771,812.00
February, 1931	1,720,474.00
March, 1931	1,881,003.00
April, 1931	1,831,228.00

May, 1931	1,815,096.00
June, 1931	1,743,189.00
July, 1931	1,698,277.00
August, 1931	1,598,869.00
September, 1931	1,555,436.00
October, 1931	1,583,005.00
November, 1931	1,497,948.00
December, 1931	1,521,552.00
January, 1932	1,527,159.00
February, 1932	1,468,059.00
March, 1932	1,574,446.00
April, 1932	1,496,077.00
May, 1932	1,453,746.00
June, 1932	1,417,856.00
July, 1932	1,357,096.00
August, 1932	1,327,016.00

OPERATING EXPENDITURES

November, 1928	\$1,936,075.00
December, 1928	2,064,632.41
January, 1929	2,104,552.74
February, 1929	2,007,945.24
March, 1929	2,099,208.11
April, 1929	2,071,386.46
May, 1929	2,064,381.77
June, 1929	2,034,409.13
July, 1929	2,045,112.96
August, 1929	2,068,388.63
September, 1929	2,050,510.38
October, 1929	2,079,042.06
November, 1929	2,091,089.31
December, 1929	2,127,053.36
January, 1930	2,190,909.95
February, 1930	2,067,112.17
March, 1930	2,120,861.86
April, 1930	2,064,328.56
May, 1930	2,102,407.49
June, 1930	2,027,258.00
July, 1930	2,038,042.00
August, 1930	1,985,045.00
September, 1930	2,079,154.00
October, 1930	2,033,163.00
November, 1930	2,003,297.00
December, 1930	2,031,148.00
January, 1931	2,058,681.00
February, 1931	1,963,391.00
March, 1931	2,026,363.00
April, 1931	1,976,430.00
May, 1931	1,967,866.00
June, 1931	1,932,832.00
July, 1931	1,925,156.00
August, 1931	1,870,985.00
September, 1931	1,890,891.00
October, 1931	1,885,424.00
November, 1931	1,829,539.00
December, 1931	1,889,887.00
January, 1932	1,806,279.00
February, 1932	1,763,572.00
March, 1932	1,762,657.00
April, 1932	1,733,486.00
May, 1932	1,672,550.00
June, 1932	1,607,822.00
July, 1932	1,590,274.00
August, 1932	1,565,767.00

AVERAGE OCCUPANCY ON 100 PER CENT BASIS

November, 1928	69.6
December, 1928	66.5
January, 1929	71.6
February, 1929	73.8
March, 1929	73.2
April, 1929	72.2
May, 1929	71.2
June, 1929	71.3
July, 1929	67.8
August, 1929	67.5
September, 1929	65.0
October, 1929	68.0
November, 1929	68.6
December, 1929	64.0
January, 1930	70.1
February, 1930	72.1
March, 1930	71.8
April, 1930	70.0
May, 1930	69.4
June, 1930	66.6
July, 1930	64.7
August, 1930	62.7
September, 1930	62.8
October, 1930	62.9
November, 1930	62.4
December, 1930	59.1
January, 1931	64.9
February, 1931	67.5
March, 1931	67.2
April, 1931	65.8
May, 1931	63.0
June, 1931	62.6
July, 1931	60.3
August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.5
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	53.6
July, 1932	53.6
August, 1932	54.6

These Pamphlets Will Help You Modernize

HOSPITALS are urged to join in the logical, sound, and simple "Industrial Rehabilitation" program sponsored by the government, which in effect only seeks the immediate carrying out of repairs, replacements, etc., that are admittedly necessary at this time and which are to be carried out in accordance with the present volume of service and income of an institution. The following leaflets and catalogs will give information concerning many pieces of equipment, etc., which will help hospitals to operate more economically and which can be advantageously used in any modernization program. Ask for them by number.

Anaesthetics

No. 344. "Puritan Gas News," a publication of interest to all connected with anesthesia, gases, oxygen therapy, etc. Published by Puritan Compressed Gas Corporation. 532

No. 290. "Suggested precautions in the use of ether, ethylene and other anesthetics." Puritan Compressed Gas Corp. c30.

Cleaning Preparations, Soaps, Etc.

No. 326. "The story of soap," an intensely interesting booklet telling in story and pictures of the making of soap and soap products. Unusually well illustrated. The Procter & Gamble Co.

Cubicle Equipment

No. 337. "Privacy in the Modern Hospital" is the title of a valuable booklet on cubicle screening published by H. L. Judd Co. After outlining the problems involved in securing privacy for ward patients, the booklet works out concrete solutions for many problems. c32

Disinfectants

No. 342. A table showing the amount of Lysol disinfectant and water necessary to make solutions of various strength, together with a description of the correct solutions to use for various purposes in the hospital. Also a dilution chart for use in the laundry. Lehn & Fink, Inc. 532

Flooring

No. 334. "Resilient Floors," an interesting photograph album showing Sealex floors designed and laid in recent years. Also contains a description of the many types of Sealex floors. Congoleum-Nairn, Inc. 232

General Equipment, Furnishings and Supplies

No. 327. Booklet describing professional uniforms for nurses and others, published by Henry A. Dix & Sons Corp. b0

No. 284. "Ten Kinds of Baths." Cannon Mills, Inc. b0

No. 261. "Nurses' Apparel and Hospital Supplies," a 32-page catalog. Marvin-Neitzel Corp.

No. 341. "SnoWhite Tailored Uniforms," and "SnoWhite Tailored Uniforms for Student Nurses," two booklets describing the complete uniform line of Sno-White Garment Manufacturing Company. Each style is well illustrated and completely described. 532

No. 323. "Standard ready dressings and supplies for hospitals," a folder showing the styles, types and sizes of ready made products. Johnson & Johnson.

No. 328. "Curity Ready Made Dressings Manual," an interesting manual showing the complete line of ready made dressings, with descriptions of uses and other informative material. Lewis Mfg. Co. L31.

No. 329. The 1932 catalog of Will Ross, Inc. Attractively printed, well arranged catalog of the complete line of hospital equipment and supplies. L31.

No. 333. Numerous interesting booklets and pamphlets describing the therapeutic effects, the method of manufacture, and medical history behind many "Roche" drug products. Hoffmann-La Roche, Inc. 232

No. 336. "Cotton, Gauze and Adhesive Plaster—Their Manufacture and Application in Surgery," an exceptional booklet of 96 pages. Published by Johnson & Johnson. c32

No. 339. "Kalmerid Germicidal Tablets," a pocket-size leaflet describing the composition, efficiency and uses of this new product. Davis & Geck, Inc. 432

No. 340. A complete series of pamphlets, many of which, such as "The Mystery of Sleep," "Why the Cat Unit?" and "When Chemists Turned from Gold to Drugs," are especially useful in teaching materia medica to student nurses. Available in any quantity. Hoffman-La Roche, Inc. 432

No. 314. "How to Obtain Maximum Service from Hypodermic Needles and Syringes," an interesting, pocket size manual on the selection of needles and syringes for each kind of service. Also contains practical information on how to sterilize, clean, and care for these instruments. Becton-Dickinson Company.

No. 332. Bulletin No. 260, describing the Powers thermostatic radiator valve, a self-operating regulator designed for vacuum or vapor steam heating systems. The Powers Regulator Co. 132

No. 348. Kenwood Mills, Albany, N. Y., have prepared a folder containing swatches in color of blankets and rugs, together with all necessary information concerning these hospital products. This folder is most useful for reference.

Kitchen and Food Service Equipment

No. 349. "Practical Planning for Hospital Food Service," a 62-page booklet published by the John Van Range Co., covering every detail of kitchen and food service planning and equipment. 1032.

No. 351. "Adobe Ware," a beautifully illustrated 12-page booklet describing the newest type of china for general and tray service. Onondaga Pottery Co. 1032.

No. 331. "Good Coffee," a monthly publication of interest to all quantity users of coffee. Published in newspaper style and containing many hints valuable in the preparation of coffee. Continental Coffee Co., Inc. 132

No. 300. "The Perfect Tray," by Helen E. Gilson, Onondaga Pottery Co. d0

No. 276. Modern Kitchens. A 70-page booklet. International Nickel Company. C30

No. 252. "Scientific Hospital Meal Distribution." Swartzbaugh Mfg. Co., Toledo, O.

Laundry Equipment and Supplies

No. 277. Laundry Owners' Year Book. International Nickel Company, Inc. C30

Sutures and Ligatures

No. 338. "The Bacteriological Control of D. & G. Sutures," an interesting pocket-size folder describing the various manufacturing processes of sutures. Davis & Geck, Inc. 432

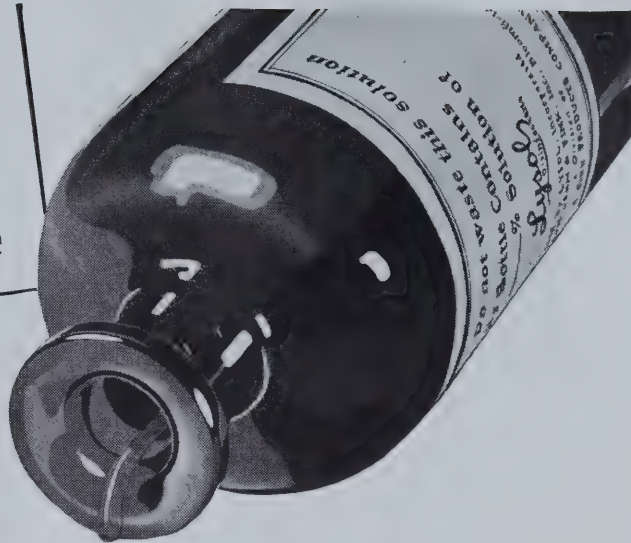
Sterilizers, Stills

No. 234. "American Sterilizers and Disinfectors." Catalog. American Sterilizer Company, Erie, Pa.

No. 213. "Sterilizing Technique Series." Five booklets. Wilmot Castle Company.

Surgical Instruments and Supplies

No. 322. "Handbook on Ligatures and Sutures," 1931 edition. An interesting booklet on the history, preparation, handling and use of ligatures and sutures, completely revised. Johnson & Johnson.



Its Double-Strength
Cuts its Cost

LYSOL NOW



TWICE AS STRONG

... in phenol coefficient

Right at a time when all hospital expense is under close scrutiny . . . when rigid hospital economy is imperative . . . when a hospital dollar must stretch as never before . . .

"Lysol" disinfectant comes through with a new phenol coefficient that cuts the cost of hospital disinfection to an absolute minimum . . . A "Lysol" twice as powerful with no increase in caustic properties . . . A "Lysol" twice as quick in dealing out death to germs . . .



TWICE AS QUICK

... in germicidal action

The phenol coefficient of "Lysol" is now 5, while ordinary cresylic preparations, as a rule, give one-half or less of this value. Thus "Lysol" chemists make possible a welcome reduction in the hospital budget . . . The special no-profit-price of "Lysol" to hospitals still prevails . . . \$1.50 per gallon in lots of ten gallons or more.



SAME PRICE

\$1.50 PER GALLON

in lots of 10 gallons or more

No commercial announcement of this radically new "Lysol" will be made until every hospital is supplied. Get your order in early. Use the coupon.



LEHN & FINK, Inc., Hospital Dept. N-10
Bloomfield, N. J.

Will you kindly ship immediately gallons of
the new double-strength "Lysol" disinfectant.

Your name and title _____

Your hospital _____

City _____ State _____

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Helping Patients to Meet Cost of Hospital Care Through Insurance

I HAVEN'T had time to go into the details of the subject of Hospital Insurance. However, I have been watching the development of these plans, and it seems to me that the only safe plan as far as hospitals are concerned is to have the policyholders in position to use any hospital and any doctor and have the policy cover the payment of hospital and doctor bill. I do not think it is a good idea for one hospital to go out and build up a scheme of this kind unless it is in connection with certain industrial units. Then, of course, it brings up the matter of medical care.

I think it would be perfectly proper for industrial concerns or policyholders working in a large corporation, a group of school teachers, or something of that kind to make arrangements with the hospital to take care of their patients on some sort of a basis. However, I do not think that this is exactly fair to the medical profession if the insurance company or the institution names the doctor. I think every individual should have the right to name his own doctor and select his own hospital and the sort of accommodations he desires.

This whole thing may develop a system of state medicine, which will make it impossible for the best doctors in the community to be given the recognition they should have in order to encourage high grade professional work.

I think there is great danger in many of the schemes which have developed in various parts of the country; and I believe that hospital magazines and the hospital association should be careful not to encourage many of these movements.

Many of these arrangements are being fostered by laymen who are out to make money. This is also unfair; and I think if the insurance laws of the states were studied, it would be found that many of these individuals are operating in opposition of the law.

I have always noticed that the large insurance companies have not been willing to take up this matter of sickness insurance, without a very large premium. Therefore, it must not be a practical thing, as they have certainly had experience and should know what is safe or unsafe. So from a financial standpoint I would not care to enter into such an arrangement. It is either unfair to the great majority of those contributing, or it will not work out in the long run.—PAUL H. FESLER.

I HAVE had no experience with hospital insurance, in fact, have not gone into it as all I have ever heard of it has not appeared to me as being workable at our institution.

Some who have tried it out seem to be rather enthusiastic over it, but all of whom I have heard have tried it out in an industrial center where most of the patients were industrial patients so that the doctor could contract through insurance with the employes of the industrial plants and could work it very nicely. But in communities where hospitals depend upon private patients who are not affiliated with industrial plants the advisability of adopting such plan has been questionable to me.—W. W. RAWSON.

NOT having had any experience with hospital insurance I have no definite information.

Two projects which I noted recently are quite similar to each other. One project provided for a payment of \$9

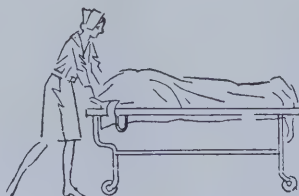
per year for a certain number days of ward care and \$12 per year for a certain number of days of private or semi-private care. In neither case did this amount cover the fees of the physician or extras. Another proposition which was presented was similar to this, but not so easily explained. Neither of these plans has as yet been in use for a sufficient length of time to ascertain how well they will meet the need for which they were established.

Personally, I am favorably disposed to arrangements of this kind but am in doubt as to whether there has been sufficient study of the proposition to assure that when it is put in operation the money collected will be sufficient to compensate hospitals for the care of the patients under the contract which it is proposed to make.

With reference to producing revenue, I believe that it is important to establish prices for different services to patients so the patient may be able to pay for these services in case they have the funds to meet the charges. Much money is lost through hospitals not having properly established rates for services to patients and having a proper charge system.—C. S. PITCHER.

WE do not have an insurance arrangement and in feeling out the field think it would not work at present. There are no funds for necessities of life and the folks who need insurance are not taking any extra burdens at present.—CLARENCE H. BAUM.

I KNOW so little about hospital insurance that I am not in a position to make any comments at this time. I realize that considerable attention is being given to this matter, but do not know just how the schemes that are being tried are working out.—ELMER E. MATTHEWS.



Protecting Your Dishes

Your investment of thousands of dollars in dishes and silverware requires the protection of safe cleaning. Brown stains on dishes and tarnish on silverware can be avoided by the use of Wyandotte Cherokee Cleaner.

Scientifically developed exclusively for dishwashing, Cherokee Cleaner produces thoroughly clean dishes, protects them from stains, and costs less to use per thousand pieces.

For Cherokee is *all* cleaner. Every particle of it exerts a dynamic cleaning action. It completely removes fats and greases and then rinses away freely, leaving a sanitarily clean surface.

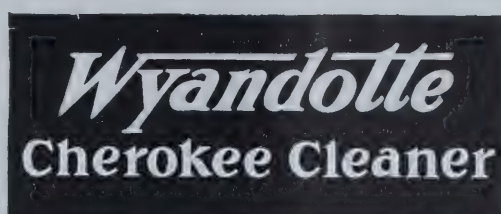
Cherokee Cleaner is definitely guaranteed to give you cleaner dishes at lower costs than you have ever before enjoyed.



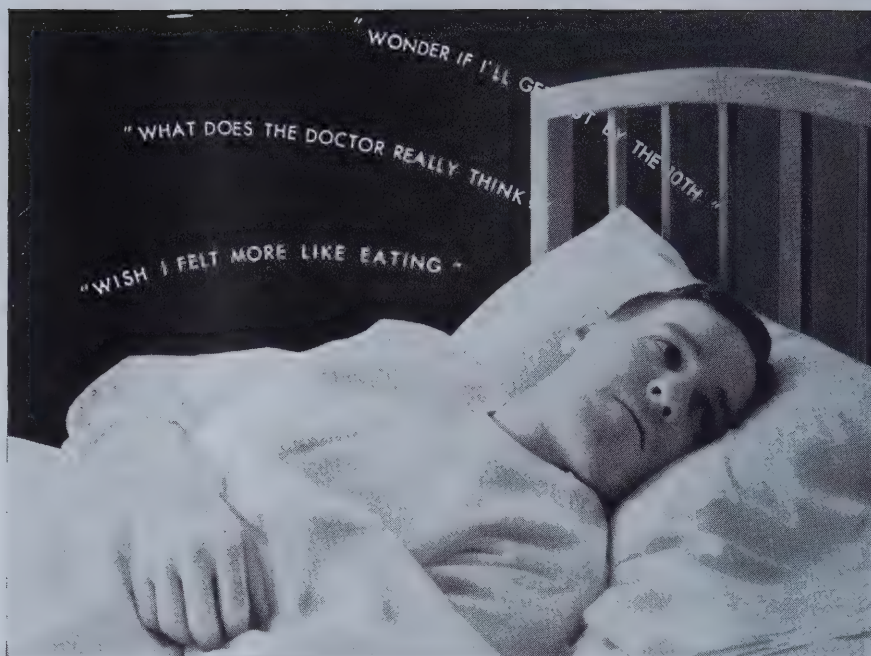
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The J. B. Ford Company

Wyandotte, Michigan



PUT YOURSELF in the Sick Bed



Before You Buy New China

RESTLESS, worried, bored with self and surroundings—what gaining patient doesn't look forward to tray time as bright spots in his day? And since the convalescent eats as much with his eyes as with his lips, the first quick impression which his tray conveys instantly sharpens or shatters the appetite—stimulates or checks the flow of juices that pave the way for a perfectly digested meal.

With physicians and dietitians so thoroughly convinced of this direct link between the tray's appearance and the appetite, it is unfortunate that gracefully shaped, colorfully patterned china still suggests to many hospital buyers high breakage and high cost. Unfortunate—because there is ample proof that this imagined stigma is not in line with the facts.

One very good customer recently volunteered an enthusiastic description of the effect of a "home-like" china on the patients—and added, "*We find practically no difference in breakage cost between our new ware and the plain service formerly used.*" Repeatedly,

careful cost records from many other hospitals confirm this statement—prove that no hospital willing to dig deep enough into costs need be content with harsh, conventional, bulky china.

There are several reasons why Syracuse China has proved so successful in leading hospitals. First, the ware itself is thoroughly vitrified—non-porous and exceptionally strong. Second, each pattern is at all times protected by a rugged surface glaze which resists chipping, prevents marring or fading. Third, a careful study of shapes—their capacity, adaptability and interchangeableness—has made it possible to assemble and serve all diets promptly and completely.

Dealers in all principal cities will gladly show you the wide range of hospital stock patterns. See them. Perhaps you have some special design of your own in mind. If so, tell our Syracuse Office. And let us submit some suggestions for patterns—they cost you nothing.

Onondaga Pottery Company, Syracuse, New York.
New York Offices: 551 Fifth Avenue. Chicago Offices:
58 East Washington St.



One of the seven trays pictured and described in the booklet "The Perfect Tray" by Helen Evangeline Gilson, chief dietitian, Pennsylvania Hospital, Philadelphia. A copy will be sent on request.

SYRACUSE CHINA

A PRODUCT OF
ONONDAGA POTTERIES

"Potters to the American People Since 1870"

A Page of Letters to the Editor

FLAT RATES FOR O. B.

Editor, HOSPITAL MANAGEMENT: Our hospital board has been considering different ways and means by which we could build up our obstetrical department, and we have been considering very favorably the flat rate for patients in this department. The board would appreciate it very much if you would send us any information, facts or ideas about what other hospitals of similar size are doing.

H. GLADYS COLLINS, R. N.,
Superintendent, Grant County
Hospital, Marion, Ind.



UNTRAINED EXECUTIVES

Editor, HOSPITAL MANAGEMENT: I was very much interested to read the editorial in the September issue entitled "Two Effects of Ousting of Competent Superintendents."

It has always been surprising to me that if we do not have a trained dietitian in charge of our dietetic department, a graduate and experienced nurse in charge of our school of nursing, a recognized pathologist in charge of our pathology department, or an adequately trained graduate physician in charge of our X-ray department, the hospital will be immediately taken off of the accredited list by the national organizations whereby those departments are represented, as well as by the American College of Surgeons and the American Hospital Association. But a political appointee or an absolutely inexperienced and untrained individual can be placed in charge as superintendent of a hospital and yet all of these organizations will continue to recognize it as an accredited institution.

It appears to me that the fault lies primarily with the American Hospital Association, which would appear to be so fearful of losing a membership that it will not take the aggressive action which would be immediately taken by the American Dietetic Association or any of the other organizations mentioned if incompetent people were placed in charge of those departments with which they are concerned. It would appear to me to be almost equally the fault of the American College of Surgeons and the American Medical Association, who could control the situation if they would, that they do not immediately remove hospitals from the accredited list and take away their classification when untrained superintendents are employed by hospital boards by reason of political or economic pressure. There would appear to be no question that politically appointed superintendents are a detriment to hospital service and likewise that it is never a real economy for a board to employ an untrained administrator solely because of the fact that he can be secured for a few hundred dollars less per year.

My own feeling is that no hospital should be allowed to retain membership in the American Hospital Association which employs an administrator who has had less than five years' experience in hospital administration either as a superintendent or as an assistant superintendent. It is also my feeling that the American College of Surgeons should immediately remove from its rating list any hospital whose board employs an untrained administrator. It is

"HOSPITAL MANAGEMENT" again expresses its appreciation of the interest which has been shown in these pages of Letters to the Editor. Again we thank those who have so kindly volunteered to answer the questions which have been asked and thus to supplement information which has been sent directly to the writer.

These Letters to the Editor will serve their purpose, which is to provide comments and information of interest and to suggest problems with which some hospitals are engaged, to an even greater degree, if readers will correspond directly with those whose inquiries appear. We would like to have copies of letters answering specific inquiries, and we also welcome comments, suggestions, criticisms, etc., expressed in letter form, from any reader.

likewise my impression that if the American Hospital Association and the American College of Surgeons took proper action they could almost immediately eliminate the problem which you have discussed in your editorial.

CHARLES E. REMY, M. D.,
Superintendent, Minneapolis General
Hospital.



EMPLOYEES' IDEAS

Editor, HOSPITAL MANAGEMENT: In the September issue, page 17, I note a reference to employees' ideas. From past experience I can state that this is very useful and justifiable, and it has been my practice for the last three or four years to have a suggestion box, into which suggestions from employees are placed. These are collected once a month, and as a stimulant to the staff the person who, in the current month, submits the suggestion considered by the management as of the greatest advantage to the hospital as a whole receives one day off, with pay, in the following month. I have found this a very valuable activity, and many splendid suggestions are received. After all, what is more logical than to expect that people doing a certain class of work may have some ideas about it themselves?

Broken dishes: I had in practice in the hospital where I was formerly stationed, and have just instituted it here, a contest between maids. The one showing the best percentage reduction in breakages, compared with her previous month's record, receives one day off in the following month, with pay. This system has been most satisfactory, breakages being reduced very, very materially. Under this scheme we are actually paying, one might say, for

breakages rather than charging for them.

These ideas or practices give the staff an interest in the hospital which, after all, they should have, and the more we can get our staff thinking, better results we are going to receive.

S. R. D. HEWITT, M. D.,
Superintendent, St. John General Hospital, St. John, New Brunswick.



PLANS LOCAL COUNCIL

Editor, HOSPITAL MANAGEMENT: On page 23 of the September issue I note you refer to Dr. Goldwater's recommendation (at Detroit convention) that a Council on Hospital Accounting be established. We in Toronto, like other cities, are passing through a very critical time, so far as our hospitals are concerned. The creation of such a local council composed of representatives of the various city hospitals has been proposed and will doubtless shortly be considered. I wondered if you had any information as to the best way to create and develop such a service, or if you had anything available, descriptive of the successful operation of such an effort elsewhere.

Trusting I am not causing you too much trouble and asking that you accept my congratulations on the excellent account published on the convention.

H. A. ROWLAND, PHM. B.,
Superintendent, Riverdale Isolation
Hospital, Toronto, Ont.



ASKS ABOUT COURSE

Editor, HOSPITAL MANAGEMENT: Would you kindly inform me if the American Hospital Association has a course in hospital administration arranged or planned for the coming year? Would appreciate any information, data, etc., you may send me.

OHIO.



LIKED EARLY REPORT

Editor, HOSPITAL MANAGEMENT: The September issue arrived the day after I wrote to you regarding its non-appearance. I was concerned because of the chance of its being lost during my absence in Detroit. It was a pleasure to get a report of the convention so soon and indeed it was worth waiting for.

I should appreciate very much if you will send me the same information that you gave C. A. Sharkey on page 15 of this issue regarding a Rotary Club talk.

EDNA H. NELSON, R. N.,
Superintendent, Ryburn Memorial
Hospital, Ottawa, Ill.



SUGGESTIONS ON COURSE

Editor, HOSPITAL MANAGEMENT: I read with interest each month your communications on the training course for hospital administrators and have been more or less familiar with the efforts made in the past to develop such a course. One of our difficulties seems to be that at the only stage in one's career when he could afford the time to go to college, one is unlikely to have developed an interest in the subject of hospital administration, and later, when individuals find themselves in this

profession, economic conditions make it impossible to drop out and take a full-time course.

I am wondering, however, if something on the correspondence course idea could not be developed, and through our association a number of hospitals located around the country might be "approved for the training of hospital administrators." This would, perhaps, afford opportunities for individuals to get practical training, possibly on a part-time basis, in model institutions located near enough to them so that the problem of residence might be eliminated. This might also serve to emphasize which were the well organized and conducted institutions, giving them certain prestige, and taking advantage of their experience to raise the standards of other institutions in their locality by this contact with their active heads.

This suggestion is of too informal a character to justify publicity over my own name, but you are welcome to the thought if it is of any value in stimulating further discussion.

As an added thought, I believe a great deal of value would attach to a candidate for a superintendency who had served a period of training in one of our large and nationally known hospitals, and any plan which made possible such an affiliation would give this advantage to candidates and would help to standardize the important procedures of administration by having a larger proportion of superintendents going through the same mill.

F. STANLEY HOWE,
Director, Orange Memorial Hospital,
Orange, N. J.

WILL YOU HELP HERE?

Editor, HOSPITAL MANAGEMENT: Will you please send to me literature on the following subjects?

Group hospital insurance.

Duties of ladies' auxiliary.

How to conduct an out-patient department.

SOPHIA PIEPER,
Superintendent, Lutheran Hospital,
Omaha, Neb.

INTERESTED IN INSURANCE

Editor, HOSPITAL MANAGEMENT: Like so many of my brother hospital administrators, I am very much interested in the various insurance plans which are being tried out which will aid hospitals in receiving pay for treatment of patients. If you have any information on these various insurance schemes, will you be so kind as to forward it to me as soon as convenient?

JOHN N. HATFIELD,
Superintendent, Pennsylvania
Hospital, Philadelphia.

THE SACRAMENTO PLAN

Editor, HOSPITAL MANAGEMENT: Your last issue contained several references to insurance plans for hospital care. You perhaps will be interested in the enclosed literature that describes a plan we have recently put into effect. You will note that this is the first time in the United States as far as we can learn where two competing hospitals and the professional groups have united to put over anything of this nature.

As to its success, it has succeeded beyond our hopes. We have been going only since June 15, with time out for



community chest activities, vacations, state fair, and all the other vexations and delays we could possibly have, but we now have close to 600 members and growing daily, many of the members coming in without solicitation.

Both the dailies of the city have given us liberal publicity, and department stores, banks and other large corporations have brought their employees together especially for us to meet and explain the plan. It has also been recommended by the statewide committee of the State Employees Association representing 10,000 employees of the State of California, of whom 2,500 are in the local chapter.

The professional groups have duly appointed their representatives and everything is working out nicely because of the community basis on which the plan has been placed. It opens doors for us where any commercial concern would not be given a moment. For this reason, we believe a plan of this kind is far above the Baylor Hospital or Houston plans, for the commercial organization stands between in both those cases. As this is a community of over 100,000 with rural territory of at least that many more on which to draw, we expect to have a membership of 5,000 before the end of another year.

Thus far the executive secretary and myself have contacted all the leading firms of the city. Lately we have taken on two men well known and of good standing to follow up our efforts as we are not able to handle all the business that is coming to us. These two are on a commission basis, getting \$2.50 for each member they obtain and nothing more.

R. D. BRISBANE,
Superintendent, Sutter Hospital,
Sacramento, Calif.

PUBLICITY AND INSURANCE

Editor, HOSPITAL MANAGEMENT: The hospitals of Milwaukee feel that there should be some publicity regarding hospitals in general. I am writing to ask if you have a short talk, or a copy of some



speech, suitable for radio presentation, which will take from 12 to 15 minutes. The subject must be regarding the modern hospital in comparison to ancient hospitals.

We are very much interested in hospitalization insurance plans, and in reading your last issue you say, if we are in need of any information regarding hospitalization insurance plans, please write you, therefore this letter. I am sure you have excerpts of many plans and no doubt will be of help to us.

L. C. AUSTIN,
Superintendent, Mt. Sinai Hospital,
Milwaukee, Wis.

HE SAYS, "THANK YOU!"

Editor, HOSPITAL MANAGEMENT: It is generally considered that our convention at Detroit was an outstanding success. It is my conviction that the success of large affairs is not dependent only upon one or two individuals, but on the co-operation of a large number. However, there are individuals whose work is outstanding. During the convention there was a great deal of excitement and we failed to express our recognition to those who so materially aided our program. I wish to express my gratefulness and that of the Protestant Hospital Association to many executives for the valuable service rendered throughout the year for the American Protestant Hospital Association. If in any way I am in position to return a favor, it will be a pleasure.

A. O. FONKALSRUD, PH. D.,
Superintendent, Mansfield General
Hospital, Mansfield, O., 1931-32
President, Protestant Hospital
Association.

"HOW'S BUSINESS?"

Editor, HOSPITAL MANAGEMENT: I wonder if your staff man who handles "How Is Business?" would send us the necessary information to plot our own hospital graph to compare with the one which he is running along in HOSPITAL MANAGEMENT?

In connection with this graph, I believe it would clarify the graph to the casual observer if informatoin were placed at the side to indicate what the up and down figures represent. In the case of the one graph, by comparison with the list it is easy to see that the line follows the figures for percentage of occupancy, but the other line is not so clear.

H. E. BISHOP,
Superintendent, Robert Packer
Hospital, Sayre, Pa.

INSURANCE

Editor, HOSPITAL MANAGEMENT: I am very much interested in articles on insurance and am trying to find one that will suit us.

MAUD E. VARNADO,
Superintendent, Laurel General
Hospital, Laurel, Miss.

ASKS ABOUT COURSE

Editor, HOSPITAL MANAGEMENT: Please furnish me with information regarding a course in hospital management, such as educational requirements, time required for completion, probable cost and experience necessary.

WYOMING.

A CORRECTIVE FOOD

that makes patients change their minds!



YOU KNOW how patients feel about most corrective foods. They don't like them—and a good many times they won't eat them. That's why we believe you'll be particularly glad to know about Heinz Rice Flakes. For this cereal makes patients ask for *second* servings!

These flakes are delicious. Crisp and crunchy. Patients take to them as to a good dessert! And they're just as effective as they are good, for *corrective cellulose is combined with Heinz Rice Flakes.*

This added corrective cellulose gives these crisp flakes the same

gentle, safe regulative effect that Nature's corrective cellulose gives to fruits and vegetables!

*Only Heinz can offer
added corrective cellulose*

The H. J. Heinz Company extracts corrective cellulose from the whole rice grain by a special process developed by Heinz scientists working in collaboration with the Mellon Institute. It is a soft, fluffy, tasteless

substance that absorbs several times its weight of moisture after eating—and forms one of the gentlest, mildest types of bulk. No other cereals but Heinz supply this valuable added element.

For more detailed information about Heinz Rice Flakes, let our representative call. With your permission, he will also arrange for a generous free trial at no cost to you. The coupon below will bring him to you.

HEINZ RICE FLAKES •

H. J. HEINZ COMPANY,
Dept. HM-10, Pittsburgh, Pa.

Please have your salesman call, regarding Heinz Rice Flakes.

Name

Street

City State

THE ONLY READY-TO-SERVE CEREAL THAT
CONTAINS ADDED CORRECTIVE CELLULOSE

"ONE OF THE
57
VARIETIES"



Cannon Towel No. 588 . . . cost 'way more in 1929. Now you can get it for

40% less

Such value enables you to lower service costs without lowering service quality.



A TOWEL IN THE HAND

IS WORTH TWO IN THE PICTURE

TEST after test has proved the super-quality, super-thrift of Cannon towels. But, even though word of these tests has reached you, you may still doubt that Cannon towels *are* more absorbent, *do* launder better, *will* stay young and fresh and whole longer. You may doubt that you *can* get more for your money in Cannon towels.

Any housewife, any Cannon towel user, will tell you that these results are real. But that would still be hearsay, not yet actual proof for *you*.

If you're open to conviction, and ready to be shown the bargain of bargains in towels, the best way to settle the question is to get a real,

honest-to-goodness towel before you and put it to your own tests.

Most convincing of all is to give Cannon towels the acid test of *working for you*. Then you'll learn, beyond the shade of a doubt, that square-inch for square-inch, they're all they're claimed to be.

Call your jobber in and have him bring you the latest Cannon samples at the latest low-down prices. See for yourself. . . . Cannon Mills, Inc., 70 Worth Street, New York City. World's largest producer of towels and sheets.

Cannon towels are manufactured in accordance with Simplified Practice Recommendations No. 119-31 U. S. Dept. of Commerce Bureau of Standards.

CANNON TOWELS

HOSPITAL MANAGEMENT

A Practical Journal of Administration



Five Houston Hospitals Join in Hospital Insurance Plan

"We Think That From the Standpoint of Employed People, Doctors and Hospitals, We Have the Ideal Plan," Says Mr. Jolly in Describing System and Comparing It With Others

By ROBERT JOLLY

Superintendent, Memorial Hospital, Houston, Tex.

THE great demand in the hospital field today is for hospitalization at a reasonable figure for those who do not want charity and yet cannot pay full hospitalization charges. To those who have made a study of the question it has appeared for some time that since most of our hospitals are not able to give hospitalization at less than cost the only feasible plan would be for the potential patients themselves to insure each other.

Of all the questions under consideration at the American Hospital Association in Detroit I think none created as much discussion as the subject of Group Hospitalization. In a round table I conducted we spent over an hour on this one subject and when we closed and dismissed the crowd quite a large group remained to continue the discussion. While the round table was in progress it was announced by Frank Van Dyk that all the hospitals of Essex County, New Jersey, Hospital Council had just completed a plan for group hospitalization. At the banquet Rufus Rorem, of the Rosenwald Foundation, asked a dozen of us interested in this subject to sit with him at a table where we could exchange ideas. This will explain to the curious why so much noise was coming from our table, for in discussing the subject we had to compete with the orchestra and the man with the megaphone at the other end

Here are some details of the Houston hospital insurance plan which received so much attention at the American Hospital Association convention in Detroit. It is based on the experience of other Texas plans, with modifications, and the participating hospitals feel that it is ideal, as Mr. Jolly says. In later issues descriptions of other plans will be presented. Note letter from R. D. Brisbane, Sacramento, on page 16.

of the hall. Mr. Rorem told us then that a number of people had asked that he call a special meeting at some hour next day that would not conflict with the program and let those interested discuss the matter further.

Since my return home I have received a number of letters asking for information on the plan we are putting into operation in Houston and which we think is the best plan yet evolved, which is entirely different from those used in Dallas, and somewhat different from the one in San Antonio. It must be kept in mind that all of these Texas plans apply only to groups of employed people and in any organization a certain per cent of the employees must sign contracts before they are in

force. No group of less than five people is eligible.

None of these plans include the doctor's bill, for we all feel that we are on dangerous ground when we handle anything that smacks of contract medicine.

There are three different Group Hospitalization plans now in operation in this state:

(1) A plan whereby one hospital using its own personnel as agents sells to employed groups contracts which assure them hospitalization in that particular hospital only. The money collected from such sales goes into that hospital's treasury.

(2) The same plan as (1) except that the hospital employs an outside agency to sell the contracts.

(3) A plan entered into by more than one hospital whereby the purchaser of contract may choose any one of the participating hospitals for admission, such contract to be sold by an agent of the hospital group. The money collected is placed in a reserve fund against which the hospitals charge \$5 per day for each patient and \$10 if operating room is used.

Plan (1) is the first Group Hospitalization plan operated in Texas and was put into operation by Dr. J. F. Kimball of Baylor University Hospital, Dallas, nearly three years ago. Dr. Kimball for 13 years had been superintendent of the public schools of Dallas and had so endeared himself not only to the school teachers, but to the public, that he had the ear of the citizenship of that city for anything he might say. For the benefit of his teachers he had built up a sick salary indemnity plan by which

every teacher paid one dollar a month, and if they were sick more than five days drew six dollars a day for the time lost from school.

When Baylor University elected him on June 1, 1929, to the vice presidency with office in Dallas in charge of the medical school and hospital, he at once began working on a plan that would benefit both the teachers and Baylor Hospital. He offered to give 21 days' hospitalization in any calendar year, which would include operating room and laboratory (but not fee of doctors or special nurses) for fifty cents per month. The first six months he built up a surplus of \$600 with 1,200 teachers in the group. Encouraged by the success attained with this group, in the spring of 1930 he proposed the plan to some banks, newspapers, department stores, fire department, etc. Now, after a little more than two years Baylor Hospital has 40 different employment groups of about 5,000 people who hold contracts. Recently the rate for school teachers has been raised since it has been proved by experience that they are a higher risk than other groups. The four groups which have proved to be the highest risks are (a) teachers, (b) nurses, (c) department store employes, (d) preachers. For brevity I quote from a pamphlet which Baylor Hospital distributes, which gives information concerning this plan:

Baylor Group Hospitalization Plan assures hospital service in Baylor University Hospital when needed, operating room service, anesthetics and laboratory fees, during period of hospitalization not to exceed 21 hospital days during any 12 months' period. In case the assured party should necessarily be hospitalized more than 21 days, then he shall be entitled to a discount of $33\frac{1}{3}$ per cent from the regular hospital fees for the time after the first 21 hospital days. Does not include oxygen tent, X-ray, special prescriptions, serums, doctor's fees, either physician or surgeon, nor the services of a special private nurse, but does include all usual hospital services of under-graduate nurses, nursing supervisors, interns and house staff, and routine medicines, surgical dressings and hypodermics.

Does not apply after resignation or discharge from present employment. Must be collected and paid as a group. Only full time employes of the firm are eligible for the group. Personal identification must be made by some authorized representative of employer.

Does not apply to industrial employment hazards, nor to employer's liability.

This agreement does not apply in case of purposely self-inflicted injury nor obstetrical cases, but in such cases the assured shall be entitled hereunder to a 50 per cent reduction on regular hospital fees, the discount applying only to obstetrical cases after a year of membership under this plan. Except for preliminary hospitalization pending diagnosis, Baylor University Hospital is not prepared to care for and does not accept cases of pul-

monary tuberculosis or chronic mental or nervous disorders, or acute venereal infections or virulent contagions, such as smallpox, etc. All such cases need treatment in special hospitals and this group hospitalization plan shall not apply thereon after diagnosis.

In case of epidemic, public disaster or other conditions occasioning an overcrowding of the capacity of Baylor University Hospital to such a degree that it is not possible to provide accommodations and in case adequate accommodations can not be secured elsewhere in the city, then in the face of such an emergency the responsibility of Baylor University Hospital under this contract shall be discharged by the refund to the assured of twice the amount that has been paid by the assured under this contract during the twelve months immediately preceding, and such payment shall constitute a full and final discharge of the obligations of Baylor University Hospital hereunder.

All members of the Dallas County Medical Society are eligible to use the facilities of Baylor University Hospital, and no patient can be admitted to Baylor University Hospital except under the care and authorization of some member of the Dallas County Medical Society, patient to leave hospital when discharged by doctor.

Dr. Kimball has been very generous with his time and correspondence in informing hospital representatives from all over the country who have visited him and written him and I am sure he will continue to do so.

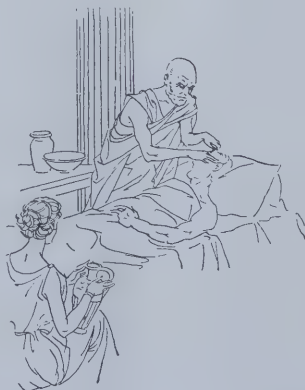
Plan (2) is one operated by Methodist Hospital of Dallas and is practically the same plan as the Baylor plan except that the Methodist Hospital employs an outside agent, C. M. Wheeler, representing National Hospitalization System. Dr. J. H. Grosch, the superintendent, advises me that on June 1, 1932, they had over 4,000 contract holders, and that their plan has worked well. He stated, however, that the plan we are putting into operation in Houston appeals to him as the best of all plans and I think I am safe in saying that both the Dallas superintendents would adopt plan (3) were they superintendents in Houston at this time. As I said in the beginning, Dr.

Kimball was the pioneer in the field and he had to operate alone and experiment until the plan was proved feasible.

Plan (3) was first operated in San Antonio 18 months ago. Two years ago S. E. McCreless of that city, a salesman for a large insurance company, who had graduated from Southern Methodist University in Dallas, and who had observed the Baylor plan in operation, decided to try it in San Antonio. He, under the name of Hospital Service Company, made arrangements with one of the leading hospitals to sell contracts for them. As soon as he began operation he found great opposition on the part of the medical fraternity. All of the plans used in Texas allow the patient to select any doctor who is a member of the County Medical Society, subject to hospital regulations. But the objection raised in San Antonio was that a doctor whose patient held one of the contracts was compelled to serve his patient in the hospital selling the contract, regardless of whether or not the doctor was agreeable to working in that particular hospital. In other words, both the patient and the doctor were limited to one hospital. The County Medical Society said to Mr. McCreless, "Your plan is good for the patient, good for the physician because hospitalization is already paid for when the patient is admitted, thus making it easier for the physician to collect his fee, and good for the hospital. But the plan ought not be restricted to one hospital. If you will get two or more hospitals to co-operate in this plan we will approve it."

Seeing that his first plan would not succeed and that the grouping of several hospitals, giving the contract holder his choice of hospitals would meet the approval of the doctors, Mr. McCreless (Hospital Service Company) immediately set about getting other hospitals into the group. He got hospitals to cooperate and for the past fifteen months the plan has been growing in favor.

A number of agencies had already solicited two of our Houston hospitals to let them put on a plan for each hospital independently, but when Mr. McCreless presented his plan we decided that while his plan would perhaps not mean as much money to us in the beginning, yet this objection was outweighed by the fact that there would be no competition between hospitals and certainly could be no complaint on the part of the doctors since they and their patients would have the choice from a group of hospitals. Our Medical So-



Agreement Between Public and Houston Hospitals

HEIGHTS CLINIC HOSPITAL, HOUSTON EYE, EAR, NOSE AND THROAT HOSPITAL, MEMORIAL HOSPITAL, METHODIST HOSPITAL AND PARKVIEW HOSPITAL OF HOUSTON, TEXAS, agree to give hospital service to

..... a member of the Hospitalization group, on the payment to the Hospital Service Company of a fee of \$9.00 a year, payable seventy-five cents (\$.75) a month in advance on the day of each month, according to the terms and conditions herein set out. Failure for thirty days to pay any installment due hereunder will forfeit this contract.

Whenever such member applies for admission to the hospital he shall then pay in advance the unpaid balance of the annual fee accruing for the then current contract year.

SERVICE INCLUDED

The service to be furnished hereunder includes \$5.00 per day private room. In case patient should select a more expensive room in the hospital he will be given \$5.00 credit on the price of his room, but he will pay the hospital the difference between the price of the room and the \$5.00. In the event a \$5.00 room is not available, the hospital reserves the right to place patient in a more expensive room without additional charge to him, until \$5.00 room is available. In addition to private room, service furnished hereunder includes board, general nursing care, nursing supervision, routine laboratory blood count and urinalysis, service of dietitians, operating room, and surgical dressings.

The services to be furnished hereunder will be furnished during the first contract year for a period not exceeding eighteen hospital days, during the second contract year for a period not exceeding twenty-one hospital days, and during the third contract year for a period not exceeding twenty-four hospital days. The services will be furnished during one or any number of periods provided the aggregate during any contract year shall not exceed the number of days specified above, where hospitalization is required by the member in excess of the days specified such services will be furnished to the member at a 25 per cent discount off the regular charges for like services. Such discount is allowed only when hospital charges are paid weekly in advance.

SERVICES NOT INCLUDED

The service to be furnished hereunder will not include services of physicians, surgeons, special nurse, X-ray, specially ordered laboratory work, nor anesthetic fee.

CONDITIONS OF HOSPITALIZATION

No service will be rendered under this contract except upon the written authorization of a member of the Harris County

Here is a copy of the contract or agreement between each subscriber and the hospitals cooperating in the hospital insurance plan at Houston, Tex. As Mr. Jolly explains in his paper, this contract is slightly different from that used for some 15 months by a group of hospitals in San Antonio, and Mr. Jolly thinks that the changes are to the benefit of the hospitals and to the patient, too, since they tend to make more specific the duties and responsibilities and privileges involved.

Medical Society and during such time as the member is under treatment and care of such physician. The period during which the service will be furnished will end at any time the member is discharged as a patient by his attending physician. After the patient has been discharged, or advised by attending physician that further hospitalization is not necessary, contract holder must pay in cash full hospital charges for service received after such advisement.

Hospital service will not be furnished hereunder in case of injuries covered by Workmen's Compensation insurance, automobile liability insurance, mental or nervous disorders, quarantinable diseases, purposely inflicted injury, venereal diseases, drunkenness, cases requiring rest cure. A member requiring hospital service at child birth will be furnished such service at 50 per cent discount of regular charges, provided such member has held this contract no less than nine months.

Members furnished service hereunder will be subject to the rules and regulations of the hospital furnishing the service.

OVERCROWDED CONDITIONS

If the member applies for hospital service hereunder, and due to epidemic, public disaster or other causes, if all the hospitals hereinabove named are full of patients so that none of them, in the judgment of their respective managers, are able to furnish to the member services contemplated hereby, Hospital Service Company

as agent will refund to said member the full amount paid by him during the then current contract year, provided, however, services have not been secured from one of the above named hospitals under this contract; in such an event a proportionate amount of fee paid will be refunded and such payment shall constitute a full and final discharge of the obligations of said hospital hereunder.

CANCELLATION PRIVILEGES

The Hospital Service Company and each of the hospitals named above reserve the right, on sixty days' written notice, to terminate its liability under this contract under the following conditions:

1. Should the number in the group of which this contract holder is a member drop below the original required percentage to secure this contract.

2. Should the fee specified herein at any time be found inadequate, at which time this contract may be replaced with a contract of a higher rate.

3. Should any of above named hospitals discontinue business, this contract may be replaced by a contract binding the other hospitals which are parties hereto, or the contract holder may be refunded the unexpired proportionate fee paid by him that has not been used for protection. In such event this contract will be no longer binding on hospital discontinuing business.

Should other hospital or hospitals offer the same service through the Hospital Service Company as agent, this contract may be replaced by a contract including such other hospital or hospitals.

None of the hospitals party to this contract shall be liable for the act of omission or commission of any of the other hospitals to this contract.

It is expressly agreed that neither said Hospital Service Company, nor any of its agents or representatives, have any authority to bind said hospital by any character of agreement in any way at variance with this written contract.

This contract shall not bind the hospitals subscribing hereto until countersigned by Hospital Service Company.

Hospital Service Company,
By S. E. McCreless, Agent.

.....
Contract Holder.

Heights Clinic Hospital,
By T. A. Sinclair.

Houston Eye, Ear, Nose and Throat Hospital,
By John H. Foster.

Memorial Hospital,
By Robert Jolly.

Methodist Hospital,
By Mrs. J. M. Roberts.

Parkview Hospital,
By J. T. Oliver.

ciety was having no meetings during the summer, but the members of the hospital committee of the society saw no objection, nor could any of the doctors to whom we presented the plan.

It would take too much space for a detailed explanation of the plan we are using. Suffice it to say that we

think from the standpoint of employed people, doctors and hospitals we have the ideal. It is very likely that we will make changes from time to time to meet conditions. We probably will add some benefits to the contract and may eventually take in the families of employed people, but not until we have proved that it is

safe from an actuarial standpoint.

In San Antonio the Hospital Service Company, calling itself party of the first part, made a contract with each of the participating hospitals, calling each a party of the second part. In Houston the five cooperating hospitals (we have invited another to participate, but it has not

yet done so) are called first party, employing the Hospital Service Company the second party. There are other improvements over the San Antonio contract between the hospitals and agent which would take too much space to explain here. The contract to be sold to employed groups beginning October 1st is also different in several points from the one in San Antonio and we think much better, especially from our standpoint.

The San Antonio contract states that a private room will be provided, while the Houston Contract states that a \$5 private room will be provided. This is done so that if a \$5 room is not available and we have to put the patient in a more expensive room we will have no difficulty about moving the patient into a \$5 room when it becomes available.

The San Antonio contract gives 21 days' hospitalization each year, while the Houston contract give 18 days the first year, 21 days the second year and 24 days each year thereafter. This is done for two reasons. First, so as not to load the hospitals too heavily the first year and second, to help as a selling point causing the purchaser to renew the second year because of increased hospitalization.

The Houston contract lays heavier emphasis on the fact that the patient when dismissed by the doctor must begin paying in advance from his own funds if he stays longer in the hospital after the doctor dismisses him.

A word of explanation may be needed concerning the discount given contract holder who stays in hospital longer than the contract time or to one who becomes an obstetrical case. The hospital does not lose the discount, but receives the amount out of the Hospital Reserve Fund. I quote from the 10 page contract between the cooperating hospitals (party of the first part) and the agent (party of the second part):

Promptly upon collection by Second Party of monies due under contracts contemplated by this agreement, Second Party will deposit in such bank in the City of Houston as shall have been designated by all of the hospitals party to this agreement the full amount of such collections less commissions accruing to Second Party thereon under the terms of this agreement.

On February 1 and August 1 of each year there shall be distributed, as herein after provided, all sums in the Hospitalization Reserve Fund in excess of any amount equivalent to \$4 for each contract holder under the group hospitalization plan contemplated hereby, provided that the ascertainment of such excess will not be made until all bills due First Parties have been paid to date. Ten per cent of such excess shall, at the time of distribution, be made to Second Party as additional compensation for services rendered hereunder. The

remainder of such excess shall be divided between First Parties on the basis of the number of days of hospital service rendered by each of the First Parties since the last day on which distribution of such excess was made.

The compensation which each of the hospitals signing this contract will receive for services rendered hereunder will be as follows:

Five dollars per day for the first to eighteenth day inclusive the first year the hospital contract is in force.

Five dollars per day for the first to twenty-first day inclusive the second year the hospital service contract is in force.

Five dollars per day for the first to twenty-fourth day inclusive for the third and each subsequent year the hospital service contract is in force, and

Ten dollars flat rate for use of the operating room.

In case any contract holder takes hospital service at the discounted rate after the maximum service has been rendered as hereinabove specified, Second Party will pay from the Hospitalization Reserve Fund to the hospital furnishing such additional service the sum of \$1.25 per day for the service so furnished. Any hospital signer hereof furnishing services in maternity cases at the reduced rate, as specified in the form of contract attached hereto, will be paid from the Hospitalization Reserve Fund by Second Party at the rate of \$2.50 per day for such service given and a \$5 flat rate for the use of the delivery room.

Any information concerning the success of the San Antonio plan may be secured by writing Mr. McCreless or the following:

Miss Elizabeth Baylor Henderson, Baylor Hospital.

Mrs. Martha P. Roberson, The Medical and Surgical Hospital.

C. K. Orrell, The Physicians and Surgeons Hospital.

Mrs. Geneva Buckner, Central Clinic Hospital.

Miss Alfreda P. Hassell, Lee Surgical Hospital.

Miss Mary L. Jastrow, Medical Arts Hospital.

The superintendents of any of the five cooperating hospitals in Houston will be glad to give any information.



Widespread Publicity for Hospitals

In the spring of 1932 it was apparent that for political reasons any mobilization of the country's resources for health and welfare work should be undertaken under private auspices rather than through a committee appointed by the President. Various informal committees were established under the National Social Work Council in the name of the United Educational Program. These committees were asked to produce publicity material which could be used throughout the country to focus the attention of the public on the necessity for supporting, in addition to unemployment relief, such important services as hospitals and health agencies, recreation, family welfare, and so forth. The American Hospital Association was represented on the Committee on Health. Material for newspaper releases, magazine articles, and bulletins has been prepared by these committees.

The Welfare and Relief Mobilization has been set up this year through the efforts of the Association of Community Chests and Councils with Newton D. Baker as chairman. This group met at the White House on September 15 to organize the movement on a national scale. Through the Welfare and Relief Mobilization numerous publicity outlets have been made available and material which the United Educational Program Committees prepared has been turned over for this purpose.

Under the auspices of the Welfare and Relief Mobilization, President Hoover and Mr. Baker will make nation-wide radio addresses on Sunday evening, October 16.

Through the Newspaper Enterprise Association a statement by Paul H. Fesler, past president, American Hospital Association, emphasizing the need of the hospitals, will be sent throughout the country.

Material has been prepared on the importance of maintaining high medical standards in the hospitals for the Science News Service, which is used by a number of newspapers.

Space has been donated in some of the big magazines, and the needs of the hospitals and other health agencies will be stressed in this advertising.

It is hoped that through these various efforts the public will come to realize the importance of giving adequate support to the hospitals in these hard times.—Memo from Homer Wickenden, director, United Hospital Fund, New York.



One-Floor Building Serves Three Purposes for Children

Crippled Children's Unit of St. John's Sanitarium, Springfield, Ill., Is Home, School and Hospital for Little Patients

"A MODERN plan realized" is a phrase descriptive of the building for crippled children at St. John's Sanitarium, Springfield, Ill., which includes a hospital, home and school for crippled children complete in one unit.

The location, building, equipment, management, medical and nursing staff all together furnish every facility that this day and age can offer for the care of crippled children.

The location is in a community which has been an active center for many years in the care of crippled children. The building is located on a beautiful tract of land near enough to Springfield for convenience and far enough out for fresh air, quiet, and advantages of rural surroundings, with a large farm in connection.

The building, erected in 1931, is arranged to include every facility for hospitalizing, home training, and schooling of crippled children.

It is a one-floor building—no steps—arranged with abundance of sunshine and light in every room and hallway, with fresh air taken directly from outside the building in winter time, and passed through the heat of the radiator as it enters the building.

With the administration office centrally located there is a large east and west wing containing 100 beds arranged in two- and three-bed rooms, except one ward in each wing. The central hall between these wings leads north by the general purpose rooms. The building faces south, with the main entrance in the center. This entrance leads into a reception room,

with the administration office on the west side, a conference room on the east, and the north door leading to the hallway.

The main hallway leads north by the operating room, plaster room, treatment rooms, large auditorium and playrooms, the school rooms, library, occupational rooms, dining room, and kitchen. From the north end of the hallway is an incline leading to the basement where there is another large work and playroom, and also a laundry. The east and west hallway leads to either wing of the building where the children are quartered.

Centrally located in each wing of the building are the bath and toilet rooms. The large bath rooms contain showers, tubs, foot baths, and a long row of wash stands of varying height to make it as convenient as possible for the children who use

them, and a swimming pool is under construction designed particularly for the use of the infantile paralysis cases. The toilets are conveniently arranged so that children using wheel chairs may go and come.

There is a large playground adjoining the building on the west and here is located a well arranged solarium where the children are given the benefit of sun treatment.

The equipment includes everything of known value for the treatment and care of crippled children, from the well equipped operating rooms to the well equipped playground. The plaster room is equipped for suspending the patient in any desired position while applying the plaster casts. The treatment rooms are well equipped and include all forms of electrical treatment as sinusoidal, ultra violet, infra red, which are among those most used. The school room, occupational room, playrooms, dining room, and kitchen are all fully provided with the latest equipment.

This institution is managed by the Hospital Sisters of St. Francis, ably directed by the Very Rev. Msgr. Joseph C. Straub, who is the director of the entire Sisterhood.

Children crippled are admitted regardless of race, creed, or residence, and are served at a very low rate.

The children are carefully classified and handled. The infantile paralysis cases have the benefit of nurses trained for this special work, who give them massage, light muscle exercise in the treatment rooms and under water, and sinusoidal treatments



A. H. A. Trustees Pick Milwaukee in '33

Announcement is made of the selection of Milwaukee as the city for the 1933 convention of the American Hospital Association. Those who attended the previous convention in Milwaukee will be glad to hear of this choice, for they will remember the excellent meeting halls, as well as the convenient and adequate space for the exposition. The dates for the 1933 convention are announced as September 11 to September 15.

A factor influencing the selection of Milwaukee was A Century of Progress, the world's fair to be held in Chicago beginning June 1 and which will be open at the time of the A. H. A. gathering. Since Milwaukee is only two hours from the fair grounds, the 1933 choice of that city will mean that every one who attends the A. H. A. meeting also may have an opportunity to visit the world's fair.

CLEVELAND OFFICERS

The Cleveland Chapter of the National Executive Housekeepers Association at its annual election elected the following new officers:

President, Mrs. Adele B. Frey, Hollenden Hotel; vice-presidents, Martha Woodhouse, St. Luke's Hospital, and Mrs. Clara Hills, Fenway Hall; treasurer, Mrs. Grace Newcom, Sovereign Hotel; recording secretary, Miss Arlene R. Lance, Mayflower Hotel, Akron.

Board of directors: hotel, Mrs. Eva B. Rose, Belmont, and Mrs. Agnes Storz, Wade Park Manor; apartment-hotel, Mrs. Ella Reeves, Hawkins; club, Mrs. A. L. Thorpe, University Club; hospital, Mrs. Cornelia Vredenburg, Akron City Hospital.

"HOW TO RAISE MONEY"

"How to Raise Money," by Lyman L. Pierce, is a manual of tested methods for raising money for all types and sizes of philanthropic and charitable institutions. Money raising problems of universities and colleges, hospitals, churches, community chests, charities, Y. M. C. A.'s, are set forth, based on the author's own experience. Harper & Bros., New York, price \$3.



according to the exact need of each muscle involved. The spastic cases have the benefit of special training in nerve and muscle re-education, and in some cases surgical methods are employed with benefit.

Cases of tuberculosis of bone or joint have the benefit of all measures of known value, including the recently developed and valuable method of maggot treatment, which is used following the surgical removal of diseased tissue.

Children with club feet, bow legs, knock knees, and other deformities are surgically corrected.

Because of the arrangement of the building and the equipment many of the children are able to attend school in wheel chairs. Others who are not able to leave their beds may carry on part of their course, depending upon their condition. And many of the children benefit by the training in the occupational room where they are taught sewing, rug weaving, basket making, painting, and other employment, and the children are assigned work here according to their condition.

The floor plan above and the illustrations below and on the previous page help the reader to visualize some of the practical features of the new unit for crippled children of St. John's Sanitarium, which is operated by personnel of St. John's Hospital, Springfield, Ill.

The medical staff includes leading specialists of Springfield. The nursing staff includes the Sisters and the nurses from the nursing school at St. John's Hospital. There also are nurses trained for special treatments, a degreed school teacher and an occupational therapist.

This unit is well supported by all the active agencies in this community which, together, give the crippled children completely rounded out care.



Important Problems of Today, As Seen by A. H. A. Leader

By PAUL H. FESLER

Superintendent, Wesley Memorial Hospital, Chicago; 1932 President, American Hospital Association

TRAINING EXECUTIVES

The time has come when there should be some distinction between the tried, well trained, successful administrator, and the new, inexperienced, improperly trained and the unfit type of superintendent.

It would seem desirable to follow the plan of many other organizations in the fixing of such standards by establishing fellowships by the A. H. A. or through an independent College of Hospital Administration.

A feasible plan along such lines might be worked out by the A. H. A. or other suitable group which would be responsible for the standards for hospital administration and the awarding of some form of special designation to those who are worthy of the great calling of hospital administration in order that hospital trustees can select their administrators more intelligently in the future.

CRIPPLED CHILDREN

A hospital of 50 beds serving seven or eight states will never be able to correct the deformities of forty or fifty thousand children. During the past few years poliomyelitis epidemics have occurred in many sections of the country. In most instances the possibility of prevention and research has been entirely neglected by both the hospitals and the medical profession. Hospitals should take the lead in such programs.

I feel that our state associations should see that special levies are voted for the care of such patients in approved voluntary or private hospitals. This is the only way prevention and care of cripples can be accomplished in an effective manner. The state should care for the incurables, but acute patients will best be cared for in the community hospitals.

NURSING

The recent announcement of the Grading Committee that there would be no minimum standard suggested for schools of nursing was a keen disappointment to many. It had been fervently hoped, and the basis for this hope had been found in the first statement of purpose given by the committee, that some definite standard of measurement would be offered as an aid and support to those who

Here are some of the highlights of the presidential address of the 1932 convention. These deserve special consideration owing to the fact that Mr. Fesler, through unusually favorable circumstances, was enabled to travel from coast to coast, attending meetings and visiting hospital executives. He thus got a very extensive and at the same time intimate insight into questions which were considered of foremost importance by a large number of superintendents and others.

were earnestly seeking to improve the educational standards involved in the training of their nurses. They had in mind the wonderful results which followed a similar standardization program of the American College of Surgeons and in the field of medical education through the activities of the Council of Medical Education of the American Medical Association.

The decision of the Grading Committee now places the matter squarely before this association, and it will be our responsibility, in conjunction with all other agencies interested to take up the problem where the Grading Committee leaves it. The American Hospital Association and the American Nurses Association should make provision for a Council on Nursing Education. This council should proceed to work out a program involving a minimum standard which might serve as a guide to the weak but in no sense be a deterrent to those that have the vision and ability to forge ahead. I make this suggestion on behalf of the hundreds of hospitals which have been waiting for five years for a decision which would serve them in working out their educational programs. What I have said should not be interpreted as a criticism of the Grading Committee. The results of their work have already helped hospitals all over the country to raise standards in their schools of nursing. It has studied the viewpoint of all elements concerned; it has not yet told us how to

solve many of our nursing problems, but it has certainly helped us to see those problems and to start experiments in working them out for ourselves.

VETERANS' HOSPITALS

During the past year we have been very active in efforts to induce the Congress to amend the law to make it possible for ex-service men with non-service-connected disabilities to be cared for in civilian hospitals. At the present time service-connected cases may be cared for in any hospital but non-service-connected cases must be cared for in government hospitals.

During the year we have joined with the American Medical Association and had conferences with the American Legion and the Veterans' Administration and have had a hearing before Congress.

It still seems that the only way to obtain results is to convince the Legion that these ex-service men would receive much better care if treated in their local hospitals by the local physicians.

We have furnished the government with a list of 33,000 beds in civilian hospitals, most of which are approved by the American College of Surgeons and other standardizing agencies. We have submitted information which would show that the cost would be much less if these patients were cared for in civilian hospitals, and that the quality of care would be at least as good as that now given to these men. In fact, we have furnished volumes of proof, based upon the judgment of the leaders in the medical and hospital world, that these men would receive better care in civilian hospitals.

We have been unable to make any impression whatever upon the Veterans' Administration. After we have furnished them with absolute proof, they follow with flat statements to the effect that the average cost for caring for patients in civilian hospitals is \$8 a day and the average cost in government hospitals is \$3.50, \$4, or \$5. It seems that all of the statements differ.

At the meeting in Washington a joint committee was appointed to report on this matter. This committee represented the American Legion, the American Medical Association, and the American Hospital Association. The chairman of your committee was made chairman of this committee and at the request of the Veterans' Administration we were to make a study of the costs for the care of patients suffering from certain diseases in government, as compared to civilian hospitals. When we were

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Current Trends, Problems Reflected in A. H. A. Reports

WORKMEN'S COMPENSATION AND INSURANCE: F. Stanley Howe, Orange Memorial Hospital, Orange, N. J., chairman: The committee published a manual for the guidance of hospital executives in the handling of insurance patients, prepared by Dr. J. Rollin French, Golden State Hospital, Los Angeles. The report also suggested that hospitals make a greater effort to "sell" their services to industry.

LIBRARY: Asa S. Bacon, Presbyterian Hospital, Chicago, chairman: Statistical report of activities for year, which included circulation of 3,836 package libraries and a total of 5,666 pieces of material.

PLAN AND SCOPE: Dr. S. S. Goldwater, New York, chairman: Recommended councils on community relations, hospital medical practice, medical economics, nursing, and on hospital accounting, to be composed of "persons having expert knowledge who are willing to serve gratuitously." "There should be minimum yearly changes in personnel."

MEMBERSHIP: L. C. Vonder Heide, West Suburban Hospital, Oak Park, Ill., chairman: A net increase of 44 institutional members and 111 personal members reported.

PUBLIC RELATIONS: Dr. M. T. MacEachern, Chicago, chairman: A comprehensive outline of educational activities and methods, with several pages of references to published material. Committee urged hospitals to carry on educational programs and outlined a year's program of this nature.

HOSPITAL PLANNING AND EQUIPMENT: Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y., chairman: A review of new and improved equipment and furnishings and some suggestions for equipment planning, construction and equipment of a children's hospital or department.

TO STUDY REPORTS OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE: Michael M. Davis, Ph. D., Rosenwald Fund, Chicago, chairman: A brief review of the activities and reports of publications of the committee named, with some comments on hospital insurance schemes. "Your committee has received the impression that insurance against hospital care presents rather important possibilities and that it would be well if hospitals would explore and experiment with insurance schemes."

Although in the hurly-burly of convention week, some A. H. A. committee reports are side-tracked and few receive the attention they deserve, yet, as has been said many times, the committee work carried on throughout the year and crystallized in the annual reports is some of the most worthwhile activity of the association. Here are outlines of the 1932 committee reports, presented as an indication of what leaders in the field are thinking about and suggesting. Every person who hopes to progress in hospital management and who wants to keep in touch with current thought and trends ought to read every A. H. A. committee report carefully.

CLINICAL RECORDS: Dr. Walter E. List, Jewish Hospital, Cincinnati, chairman: Approved educational course outlined by the Association of Record Librarians of North America, suggested essentials for complete case histories and outlined a minimum requirement for a monthly report of the record librarian.

LEGISLATIVE: A. M. Calvin, Midway Hospital, St. Paul, chairman: Briefly reviewed efforts to protect hospitals against inimical laws, and presented summary of 1932 bills, federal and state. The committee warned hospitals to be watchful of state legislatures, owing to widespread necessity of more tax funds and also because efforts may be made to reduce allowances under workmen's compensation acts.

NOMENCLATURE IN UNIFORM STAFF ORGANIZATION: Boris Fingerhood, Israel Zion Hospital, Brooklyn, chairman: A new committee which reported progress in its efforts to determine upon a standardized designation for different ranks of membership in hospital medical staffs.

NATIONAL HOSPITAL DAY: C. J. Cummings, Tacoma General Hospital, Tacoma, Wash., chairman: Reported another successful, widespread observance. Contacted foreign hospital leaders, the Women's Auxiliary of the A. M. A., besides individuals and groups that cooperated in past years.

SIMPLIFICATION OF FURNISHINGS, SUPPLIES AND EQUIPMENT: John M.

Smith, Hahnemann Hospital, Philadelphia, chairman: Reported initiation of simplification projects for mattresses, pillows, rustless steel instruments, and progress or completion of similar efforts relating to surgical dressings, rubber gloves and sheeting. Reported tests on thermometers, and told of contacts with various agencies interested in testing, etc.

EMPLOYEES' RETIREMENT: Robert Jolly, Memorial Hospital, Houston, Tex., chairman: Reported that of 405 hospitals replying to inquiry regarding employees' retirement plan, none told of such a plan. Urged members to read 1931 report of this committee.

FIRE INSURANCE RATES: Dr. L. A. Sexton, Hartford Hospital, Hartford, Conn., chairman: Reviewed work of hospital fire inspections, reporting a total of 3,218 hospitals availing themselves of this free service.

BED OCCUPANCY: C. Rufus Rorem, Rosenwald Fund, Chicago, chairman: Reported on various types of hospital occupancy and showed relationship between patient day cost and occupancy. Made various suggestions regarding more uniform and more easily compared hospital statistics.

AUTOPSIES, Maurice Dubin, Mt. Sinai Hospital, Chicago, chairman: Completed organization of an associate committee on autopsies, with representative of A. M. A., A. C. S., American Public Health Association, American Society of Clinical Pathologists and Bacteriologists, and National Funeral Directors Association. Several of these groups reported organization of their own committee on autopsies. Committee summarized recent published material on autopsies and obtained information concerning legal phases of autopsies in other countries. Recommended greater attention to construction, equipment and other feature of autopsy room, and urged organization of autopsy committees by geographical sections of A. H. A.

PUBLIC HEALTH RELATIONS, Dr. A. J. Chesley, state department of health, St. Paul, chairman: Committee supplemented the extensive report of the committee of 1931, adding comments on treatment of drug addicts in general hospitals, present status of pathological examination of tissues, technique in dealing with tuberculosis, hospital milk supplies, public health statistics, and on health department training for nurses and interns.

COMMITTEE TO STUDY WORK OF GRADING COMMITTEE, Joseph G. Norby, superintendent, Fairview Hospital, Minneapolis, chairman: "More

(Continued on page 29)

"A Few Ways We Save Money, Labor and Supplies"

Here Is Practical Presentation of Economical Practices That Materially Help Reduce Expenses of One Small Hospital

By A. L. BUSTER

Business Manager, Stamford Sanitarium, Stamford, Texas.

KITCHEN PROVISIONS, SUPPLIES

To find out definitely the amount of each kind of food that was being used daily in our own institution, we worked out a form and had it printed for our use. This printed form shows and lists every article of food in the house. It shows in the next column, the amount received during the day. The following columns are so ruled that they show the amount of every article of food used in each meal in the main kitchen and also the amount used in each diet kitchen.

A complete inventory of all food is taken and listed in the first column of the form and the head chef is made responsible for it. He is charged with all that comes into the house and this can be checked by the invoices. He then has to show in the proper column, the amount of each foodstuff that is used in the preparation of each meal in the main kitchen and also the amount sent to each diet kitchen. At the end of the day, we can take the chart and by deducting the amount he has used in the various parts of the hospital during the day, from what he had to start the day with, we can tell just the amount of everything that should be on hand.

The nurses in the diet kitchens serving meals from there, can not get any supplies from the store room or kitchen without an order signed by the superintendent on duty. The nurses in the diet kitchens of each floor are required to study the list of diets needed for the patients on their floor and make up a list of food and supplies and have it checked and approved by the supervisor on their floor before the chef will allow any supplies to be sent to them. All food going out of the kitchen has to be signed for and the menus have to be shown from which the main kitchen meals are prepared.

It takes quite a little time to tell all this, but it really operates very simply and with the use of that system, you can check your supplies at

Saving money is a matter of constant watchfulness and those who desire to save should consider no economy too trivial, in the opinion of this writer. A small saving made regularly amounts to a big economy in a very short time. This paper tells how one small hospital made material savings.

any time of the day, on any day in the week and tell what you should have. If you don't have it, then it is easy to place the responsibility. We had to get the third chef before we got the plan to working. But a few check-ups at unexpected times taught the help and nurses that the matter was no joke and it resulted in much better discipline in the handling of that part of the hospital and also reduced the amount of food used—or shall I say being bought—25 per cent the first month we kept it in operation.

It stopped a lot of eating between meals in the diet kitchens by the students. Young girls that are student nurses are no different from any other school girls in having healthy appetites that they will indulge when the opportunity presents itself and it costs the hospital good money and results in overweight for the student.

Each of these forms or charts covers the food and supplies for one day only and each chart is dated and filed. The balance on hand at the close of each day is carried forward and charged up to begin the new day. We do not have a steward to watch over the provisions and see that they are not being wasted and we believe that this plan may be adapted to any moderate sized hospital.

COSTS OF FOOD NOT A GUIDE

I should like to say that the cost of your kitchen provisions from month to month is not the most accurate guide in determining waste be-

cause of the fluctuation in prices, especially in fruits and vegetables at different seasons of the year. Tomatoes in winter cost 12 to 15 cents a pound and at times they can be bought for three to five cents. That makes it necessary really to figure out the quantity that you should use and let that be the standard to measure by rather than the amount you pay for it. Of course, the number of patients and employes is always to be considered.

HOSPITAL SUPPLIES

The most commonly noticed forms of waste are extravagance in the use of gauze and bandages. The welfare of the patient should always be the first consideration, but after all material necessary is used, certainly all that is put on beyond that is waste. A conference among the staff and nurses effected a considerable saving in the amount of gauze and bandages.

Another marked saving was brought about by the making of pads for use in the operating room, especially the large abdominal pads for use in major operations. The pads were covered with gauze as economically as possible and then in the clean cases that had no drainage or pus the pads are removed and the stained part stripped off and the remainder is run through the laundry and then sterilized for use again, if not in pads, at least for other uses. After the gauze is washed white and clean and sterilized, it is just as usable as new goods.

In the good old days this item of economy was not thought of, but we find now that we are using about half the amount of these supplies that we were formerly using and frequent meetings and conferences among the students and nurses keep these matters constantly before them and are really worth while. I might add that there is no additional cost in washing and sterilizing these extra pieces that go through your laundry and sterilizer.

DISINFECTANTS

There is no use in using twice the

From a paper before Northwest Texas Hospital and Clinic Managers' Association.

No. Patients Registered _____				No. Employees _____							
Date _____				furnished meals _____							
Guests _____											
KITCHEN PROVISIONS USED											
		DIET KITCHEN 1			DIET KITCHEN 2			DINING ROOM MEALS			
Article	On Hand Morning	Breakfast	Lunch	Dinner	Breakfast	Lunch	Dinner	Breakfast	Lunch	Dinner	On Hand Night
Lettuce											
Tomatoes											
Oranges											
Grape-Fruit											
Lemons											
Apples											
Bananas											
Milk											
Cream											
Eggs											
Bacon											
Sausage											
Ham											
Canned Goods											
Pork & Beans											
Tomatoes											
English Peas											
Spinach											
Soup											
Wax Beans											
String Beans											
Beets											
Sauer Kraut											
Spaghetti											
Corn											
Canned Fruits											
Figs											
Cherries											
Pineapple											
Peaches											
Apricots											
Pears											
Preserves											
AMERICAN STANDARD											

The above gives an idea of the type of food-saving form which the author describes as an exceptionally good idea. Actually, however, there were three more columns, one headed "received during day," before the last column shown above, and another, "balance on hand at night," after that column. Each morning the balance shown was transferred to a new sheet.

amount of Lysol or other disinfectants that you may be using that is necessary to make a standard solution. The janitors are also carefully checked in the amount of liquid soaps they use, along with other supplies in the scrubbing of floors and windows. These are small details, but the price of eliminating waste in these or other departments is *eternal vigilance*, but it pays for the time it takes.

ANESTHETICS

Ether in half pound cans costs \$14 per hundred pounds less than in quarter pound cans. We had always used only the quarter pound cans, but we made some reduction in costs by using the half pound cans in major operations. If it ordinarily would take four quarter pound cans in some long operation, we used two half pound cans or one half-pound and one quarter as the need might be. If there should be some left over in a can, it is tightly corked and removed to the

dressing rooms and can be used for cleaning the skin before applying adhesive instead of opening a new can to be left on the table to evaporate.

LAUNDRY

It is my opinion that the biggest reduction in costs for the hospital in the item of laundry is to have your own laundry instead of having it done in a commercial laundry.

We made a reduction of around 50 per cent in the cost of laundry by installing our own plant and we are still doing it for half what we could get it done outside. It gives the added advantage of having at all times all the fresh linens that you need or want without calling the laundry to hurry a delivery. It is well, of course, to watch the amount of supplies that are used, such as soap, water softener, bleach and other items of that nature, and a check of one day each week of the number of pieces going through your laundry will keep that

in line. Don't make it the same day in every week; change it around.

Laundry equipment needed is to be had at bargain prices from some of the commercial laundries. I would also say that no elaborate equipment is necessary or needed to do your own work in a most satisfactory manner. If your laundry costs are high and constitute a financial problem, it is my belief that your equipment will pay for itself in six or eight months.

FUEL

Your fuel problem may be one occasioned by improper equipment for the fuel that you are using. Our heating plant was originally installed to burn coal and we used a low pressure tubular boiler. When natural gas was brought to us we changed to gas and continued to use the same boiler that was designed for coal. We had the experts of the gas company to install a set of gas burners that they claimed to be the best to be had. They apparently were so far as the gas company was concerned, but for us as the consumer it was far from satisfactory. We had them remove the burners and had one made that we had found in use in other furnaces that was much cheaper to install and also uses much less fuel. The fact remains that a boiler and furnace originally designed for burning coal cannot be as cheaply operated as one that is properly designed for the use of gas. We still face the problem of putting in a proper boiler. With present conditions, the cost of making the change is too great although the saving will be a very considerable one.

In the question of fuel, I would advise that you see that your equipment is properly designed for the fuel that you are using and then there will be very little to watch if you safeguard the amount consumed by automatic heat control.

Keep all radiators turned off in vacant rooms and cut off the fire when the building becomes warm.

REPAIRS

Repairs are a never-ending problem. They may be small and they may seem unimportant, but unless they are given attention at the proper time, they rapidly become large and expensive problems.

When your plumbing or roofs begin to show signs of getting into bad repair, there can be nothing but loss if they are not given prompt attention. We had the problem of a hot water heater that was continually giving trouble and that was expensive to repair. Finally in despair I called in again the experts of the local heating concerns and also the gas com-

pany. They wanted \$300 to install an automatic hot water heater that would furnish 100 gallons of hot water per hour. After casting around and studying the problem, I had a boiler maker to make one of new boiler steel and equipped with tubular flues that heats cold water to the boiling point in fifteen minutes and got it installed at a cost of \$135. It furnishes all we can expect to need under the most urgent conditions and furnishes it in an even greater volume than the one that I was offered for nearly three times the cost. Of all the hot water heaters we have ever used, the tubular flue boiler is the cheaper to install, heats faster and is also easier to clean of scale if you have hard water.

WATER AND LIGHTS

The problem of reducing costs in these two items is mainly one of cooperation on the part of the employees and nursing staff. We have regular conferences with our students and other employees and keep them impressed with the meaning of that awful word, "waste." A water faucet left running and lights left burning when not needed is certainly the rankest kind of waste. Inspection of the size lamps that are being used will often reveal that a saving can be made in reducing the size of lamp and still have sufficient illumination. We find that outside a few places, 50-watt lamps are large enough and that is the only size kept in the store room. If larger sizes are needed temporarily, they are installed and removed when the need for them is gone.

Leaks in water lines must be watched for and repaired promptly. An undiscovered leak in a pipe or a broken pipe that is covered in the ground and runs for a month can certainly make a difference in your water bill. Gauze and cotton pads that find their way into the sewage disposal system can cost a lot of water in flushing them out and forcing them into the main. Placards up at the proper places warning every visitor is a worth while precaution and will often prevent visitors from ignorantly or thoughtlessly clogging up your sewage. As stated in the beginning, it is largely, after all, a matter of cooperation of personnel.

INSURANCE

There is no item in the overhead expense of any hospital that is more necessary than insurance. For our purpose here, however, I shall only take into consideration fire and wind-storm insurance.

We should all carry ample protection, but insurance, like all good things, can be overdone. I wonder

how many have had their policies rewritten year after year for the same amounts without reference or consideration being given to the shrinkage of values.

A building that ten years ago cost \$50,000 to \$100,000 can be replaced today for half that amount. No use paying for more than it would cost to replace your building and equipment.

Occasionally a saving can be effected by anticipating a raise in rates. Two years ago, we had some policies cancelled that had a year to run and had then re-written for a three-year term at the current rate and saved the raise that became effective just a month later and also another raise since that time. The saving on that group of policies amounted to almost one year's premium.

How A. H. A. President Sees Current Problems

(Continued from page 25)

ready to make the study we were advised by the Veterans' Administration that this would be impossible.

As a result of this action on the part of the Bureau, we decided that our only approach was through the American Legion.

This whole movement has been carried on with the idea that if the present policy of the Veterans' Administration is not changed, thousands of men will die from lack of proper care. It is absolutely impossible to build government hospitals fast enough to meet all of the medical problems which will arise if they are to care for non-service-connected cases.

So it is to our interest to continue our fight for the hospitals for ex-service men and for the taxpayers of America.

THE NEED FOR PUBLIC EDUCATION

The people must be taught that the hospital is an integral part of the community, that their health, happiness, and prosperity depends to a very large degree upon the efficiency of all institutions, and they must be taught that support of institutions is an obligation of every person within the borders of the city. Too long have we kept silent, letting our good works speak for us, but unfortunately while we have been working toward greater perfection in hospitalization we have let go unanswered our detractors. Now we must speak as one unified body and we must make the citizens recognize that that delicate and costly machine, the modern hospital, is theirs and that they must have sufficient pride in this possession to support it adequately.

How A. H. A. Reports See Current Trends

(Continued from page 26)

than \$200,000 has been expended in gathering facts and distributing information. The (Grading) committee has announced that it proposes to conclude its labors at the end of next year and has announced that it will not recommend any standards but will make available to all interested such facts as have been secured."

The American Hospital Association committee asks what has been the effect of the Grading Committee's work on nursing education, and answers that there has been a marked improvement of student personnel and in the number of instructors employed. "There are about 200 fewer schools than 1926, but the average size of school has increased from 24 to 47 students, and the total enrollment from 51,000 to 91,000. . . . Our natural conclusion is that small schools are closing and large schools growing larger. . . . And yet, no evidence has ever been adduced to show that small schools are poor schools and large schools are good."

The A. H. A. committee then reviewed the purposes of the Grading Committee as this was announced when the latter began its work, and called attention to the fact that although a "job analysis" was proposed, "no such analysis has yet been published." The A. H. A. committee emphasized the fact that the results of the Grading Committee justified the expense, and that the volume of work done by the committee was absolutely necessary.

The A. H. A. report concludes: "It will be incumbent upon this association to set up a Council of its own members to continue the work that has been done so well by the Grading Committee. This Council will need to cooperate closely with all other agencies. It will perhaps have to undertake still further research. It will, in conjunction with others, set up for guidance certain minimum standards which may serve to raise a general average, and yet not hamper those schools that have forged ahead, and finally, and most important, this Council will be called on to formulate such plans and stimulate such sentiment within our constituency that the training of the nurse may be established upon a sound educational basis, unhampered economically by the interests of any other agency. The American Hospital Association is now offered a rare opportunity and one which may not occur again. We trust our association will rise to the occasion."

Housekeepers Will Get Merited Recognition, Is Predicted

Here Is Thoughtful Discussion of Problems of Executive Head of This Department of Hospitals, With Glimpse Into Future

By A. E. HARDGROVE

General Superintendent, City Hospital, Akron, O.

HOUSEKEEPING is a subject about which everybody knows everything that is to be known, that is, except you who are in this work; and strangely enough, you seem to think that there is still a lot to learn about it.

It appears to me that housekeeping as a department has become much further advanced in hotels than in hospitals. Most hospitals began more or less as nursing homes. Years ago, the only difference between a boarding house and the hospital was that the latter had an operating room and was staffed with nurses. So it was natural that everything was placed under the control of the nursing department. As hospitals grew, their facilities increased by the addition of various departments. However, housekeeping was last to be recognized as a separate department. Even today it is only the larger hospitals that have a definitely defined department under its own head. Many hospitals place the housekeeping under the dietary head; in fact, I know of one dietitian who has dual duties but will not acknowledge it, so you can imagine how efficiently that hospital's housekeeping is done. Of approximately 7,000 classified hospitals in the United States, 48 per cent are under 40 beds, 25 per cent between 40 and 100, or a total of 73 per cent under 100 beds. So you can appreciate why the art or science of housekeeping has not progressed more rapidly in hospitals.

There are, of course, a number of essential differences between hotel housekeeping and that of hospitals. A New York superintendent speaking on the subject expressed it all as centering in the fact that in the hotel the guest is vertical while in the hospital the guest is horizontal. This, no doubt, is the basis of most of our peculiar problems. First, the patient's room must be cleaned while he is in

What Superintendents Owe Housekeepers

"He must give you full authority over your department."

"The department head must be enabled to choose for herself help competent to do the work in question."

"The housekeeper must have proper materials with which to work, but don't forget that the selection of these materials is as much her responsibility as it is her superior's."

"I would emphasize one consideration that I fear is too seldom shown the housekeeper and that is a voice in the planning of new construction."

bed, and if it happens that it is a she who is in bed and the maid does not do the cleaning just as she thinks it should be done, then it is just too bad for the housekeeping department. The patient is much more critical than the average hotel guest—he is there because he is forced to be there by illness, his mind is centered on sanitation and cleanliness, and any slip is greatly emphasized. So, I believe that the average hospital patient is more critical of the housekeeping, particularly as applies to maid's work, than the average hotel guest. We must take this into consideration in the hiring and training of our floor maids.

I presume the worst destructive agent in the hotel is alcohol, and judging by some of the Volstead brands I have seen, it ought to be able to eat through most anything. In the hospitals we are confronted with many medicinal stains caused by accidents—iodine, tannic acid, picric acid, mercurochrome, and other tar dyes. So, hospital cleaning does become somewhat more complicated than hotel cleaning. Patients are continually upsetting something or other and, of course, all rooms must be kept spotless at all times.

Since the usual hospital patient is in his bed 24 hours of the day, our bed linens get more active service, but the time element is not the worst factor. It is the many accidents that occur to the bed linens. I have known of hospital cases where it was necessary to change the bed as often as 15 times a day. Many a hospital sheet is washed twice a day. It probably is no wonder then that the hospital field has discussed the linen problem to the exclusion of other housekeeping problems that are much more important and of greater economical concern. In reviewing the hospital literature on the subject of housekeeping I found practically nothing, but I did find a great amount on the handling of linen. There apparently is no way in which the hospital bed linen can be kept under as accurate control as can be done in the hotel. You determine a schedule for the changing of linen, allot as much to each patient as the schedule calls for, and then allow a reasonable reserve, but when emergency occurs, the patient must have clean linen or your system falls down. We are many times too prone to spend more money for labor in checking than what we can possibly save in linen. Just as the air mail slogan is "The mail must go through," so the hospital slogan is "The patient must be cared for," and when the system interferes we have no choice but to consign the system to that proverbial warmer climate.

The outstanding difference, however, is in the comparative standing of the housekeeping department with other departments of the hotel or hospital. In the hotel there would be the four major departments—accounting, catering or commissary, housekeeping, and engineering—so, housekeeping becomes one of the major departments. In the hospital, however, those departments that contribute to the professional care of the patient, as medical, nursing, dietary, X-ray, pathological, physical therapy,

From a paper before Ohio Chapter National Executive Housekeepers' association.

overshadow the housekeeping. In fact, housekeeping becomes the servant of them all. Accordingly, from a departmental standpoint, I believe that the hospital housekeeper is in a more difficult position than that of the hotel. It is through the efforts of an organization of this kind, however, that you will be able to adjust this difference and raise the standard of your department in the hospital.

Where shall we classify housekeeping? An art may be defined as the skillful adaptation of means for the attainment of an end. Certainly this fully applies to your work. Likewise, there is sufficient of a technical nature involved in your duties to give it the attributes of a science. Too many times, I fear, however, that it is just a job. The responsibility rests on the housekeeper herself. It is you that is going to determine whether your position is going to have a professional standing or whether it is going to remain just a job. So that brings me to the consideration of what qualifications a housekeeper should possess in order to make the most of her position.

Executive ability naturally takes the position of primary importance. Without that she is useless. She must be able to organize her work efficiently and direct the activities of her employes. She must command respect and at the same time be fair and just to those in her charge. But, granted that she is an efficient executive, there is a definition of an organization that I consider it most worthwhile to always bear in mind. Nothing more true has ever been said than that "an organization is the lengthened shadow of one man." I have seen the character of a department change almost over night by the changing of the person in charge. Your employes will unconsciously reflect your ideals and the attitude with which you approach your work. No organization will have a greater ideal of service than its head. So, be to your employer and be to your work what you expect of your employes.

The housekeeper who transcends the position of a forelady of a cleaning squad will be the one who has technical knowledge of the materials that she is using. As you know, probably as much to your regret as to mine, there appears to be countless salesmen of cleaning compounds. Many of these materials are worthless, many are efficient chemical compounds put up in fancy container under a fancy name and possibly colored, for which we are asked to pay an exorbitant price, when the same thing can be bought at a fair price



On this page and on page 32 are two views of the magnificent nurses' home of City Hospital, Akron, which indicate some of the responsibilities of the housekeeping department of that institution in the matter of cleaning.

in a simpler package. Then there are different types of textiles that come under the housekeeper's charge. The housekeeper of the future should have a specialized knowledge of the composition, structure, or characteristics of these various supplies or commodities so that she can act as a consultant or adviser to the manager, superintendent, or purchasing agent in making purchases for her department. In order to progress, new materials and new measures must be tried and proven before adoption. Nothing is more disconcerting or disappointing to a manager than to give some commodity to a department head for trial and receive no report. You call his or her attention to this request and finally you receive a report that is worthless. That department head may possess good mechanical knowledge of her work but she lacks the technical knowledge to make an intelligent and comprehensive report covering the value of new methods and new materials. So, I would stress this point above all others, namely, a technical knowledge of your work, if you are to make a profession of your position.

The housekeeper must be a teacher. Every member of her department must be trained to do the work according to the routine of her organization. Different materials require different methods of use, and here again technical knowledge is essential. To give a brush or a mop to an employe and point out the corridor is too often the method of operation in many departments. Efficiency can only be reached by teach-

ing each member to do her job the best that it can be done regardless of how menial it may be.

I sometimes think that a housekeeper should have the eye of the amateur detective who is made the hero of our modern thrillers—the one who enters the room, takes one look around and "you can tell by the look in his eye that he can describe every article in the room." So with the housekeeper—she must ever be on the lookout and be able to spot any slips in the work of her employes. But in addition to cleanliness, there is another quality just as important, and that is attractiveness. So, the ideal housekeeper should have an element of the artistic in her makeup and bend her efforts to make her hotel or her hospital just as attractive as she strives to make it clean.

Today the great drive is for economy. It undoubtedly is going to have its beneficial effect. Many of us have found that we can do just as good if not better work with much less expenditure of money. Most people, if given a generous budget, can produce good work, but it is the efficient administrator who can organize a smooth running department with a minimum number of employes and teach them to do their job with the least amount of supplies and with the least amount of damage to equipment. Again I must emphasize the value of technical knowledge of your supplies—the greatest economy is in the selection of the right material for the purpose for which it is to be used. Labor, supplies, and replace-

ments are all lessened by use of correct materials.

In a hospital particularly the housekeeper must be equal to emergencies. Many department executives are excellent as long as the work progresses as originally planned, but let an emergency occur that calls for revision of the routine, then the real executive demonstrated her ability. The administrator of an organization has a very much appreciated sense of security when he knows that the heads of his departments are equal to any emergencies that may occur.

Another difficulty that all employers of labor and department heads who come in contact with salesmen must avoid is to be influenced by personalities. We cannot play favorites among our employes, and we cannot be influenced in our purchases by the personality of the salesman. There are companies that depend upon the latter to sell the ordinary compound in the fancy package, and it is rather a difficult thing for all of us to avoid. The best defense is to maintain as nearly as possible an open mind regardless of external influences until the actual results are at hand.

I have already spoken of the housekeeping department in the hospital, particularly as being the servant of them all. It takes a housekeeper with a real ideal of service to fulfill her obligation to all the other departments without getting the feeling that she is being imposed upon, or that they do not give her position just recognition. A few years ago we used to speak of this as the development of an inferiority complex. I do not know what the psychologist of today calls it, but the fact still remains true. It is a difficult position to fill when you are at the call of all departments. Again I would express my opinion that it is the housekeeper who has the highest ideal of being of service to an organization who will take the least personal cognizance of the demands that are placed upon her department by the others in any organization.

I have come to the last quality I will discuss, that of cooperation. There are innumerable stories that have been told to illustrate the fact that no organization can be a success without the full cooperation of all its component parts. I do not believe there is any need of further amplification. Absolute zero in expressions from an employee to me is for someone to say, "That is not my work." Every member of an organization is working not for his part, small or large, but for the entirety. The whole breaks down if any part



Here is a glimpse of the cafeteria of the nurses' home of City Hospital, Akron, O. Another view of an interior of this splendid home is shown on the preceding page.

fails. Department heads should have the greatest feeling of freedom in calling the attention of one to the other of certain work that needs to be done, and the fullest measure of cooperation should be given in seeing that the whole organization is made a success.

I have noted a few of what I consider the important qualifications of a housekeeper. Now, a word or two regarding what the manager or superintendent owes to you. First, he must give you full authority over your department. Centralization of authority is the foundation of any successful organization. Your help cannot be expected to recognize your responsibility if your employer does not do so himself.

Next, the department head must be enabled to choose for herself help competent to do the work in question. Any employee hired or maintained over the head of a department will eventually undermine the morale of that department.

We again come to equipment and supplies. The housekeeper in order to succeed must have proper materials with which to work, but do not forget that the selection of these materials is as much her responsibility

as it is her superior's.

Finally, I would emphasize one consideration that I fear is too seldom shown the housekeeper, and that is a voice in the planning of new construction. Here again the housekeeper must have fitted herself to assume this responsibility. We ourselves happen to have one of the world's worst buildings to maintain, and our lesson was learned through sad experience; so a few years ago when we began to plan for a new surgical building and a new nurses' home costing over one and one-half million dollars, just as much attention was paid to economical and convenient maintenance as was paid to the comfort of the patients and nurses. The housekeeper's needs were given full consideration throughout. There are now available so many refinements in construction which, it is true, somewhat increase the cost in the beginning but which later during operation pay high dividends in cleanliness and economy. Accordingly, a housekeeper can do much to make herself a success before a building is built, if given the opportunity, and I would strongly urge that you insist upon obtaining just consideration for your department from the architect and manager when new construction is being planned.

We have discussed the work of a hotel and hospital housekeeper, we have described some of the qualifications that she should possess, and we have noted certain considerations that are due her. The one remaining subject is: what as to her future? From the standpoint of the hospital



there appears to be a direct corollary between the development of the hospital dietitian and the future of the housekeeper. At first hospitals had in charge of their food service a more or less competent cook who served under the nursing department. As the value of a diet grew in treatment of disease, we began to prepare in our colleges girls specially trained in dietetics; and soon we had dietitians in charge of food service, made a separate department of it on a par with any other professional department of the hospital, and called it dietary. So, in housekeeping we have begun by placing women in charge, whom we consider to be particularly competent to manage a household, just as the cook was competent to manage the kitchen. Now that our colleges are graduating a surplus of young men and women, they must find new opportunities for their graduates. The position of housekeeper certainly presents a most favorable one. The same Home Economics Department which provides the student with an opportunity to specialize in dietetics could, with very little change in the curriculum, provide a course in hotel or hospital housekeeping.

Many of the essential subjects are already offered — chemistry that would lead to the chemistry of cleaning materials, structure and testing of textiles, control of help, sanitation, purchasing, budgeting, interior decorating, and others. A graduate of a properly arranged course in Home Economics could be very well provided with the technical knowledge that would equip her to take the share of responsibility in hotel and hospital management that she should assume. This would in time place the department on a professional basis comparable with other departments of the organization. In the meantime, it is the initiative that you are taking to provide yourselves with this technical knowledge, that could be acquired in such a specified course of study, which will demonstrate the value of a technically trained housekeeper and prepare the way for this further development. Therefore, I wish again to heartily commend you in the initiative that you are taking to better prepare yourselves for your positions. I do not know what name they will give this technically trained housekeeper of whom I have spoken, and I do not care. I would much rather think that, instead of the name dignifying the position, you through your efforts to make yourselves qualified and more valuable are going to bring greater credit to the title of housekeeper.

Think of This Before Asking for Aid from Tax Funds

HOMER WICKENDEN, director, United Hospital Fund, at the request of HOSPITAL MANAGEMENT, thus summarized the thought and suggestions presented at a round table of the A. H. A. on methods of obtaining payment of service to indigent patients:

Summarizing the points brought out at the discussion on "Methods of Obtaining Payment of Service to Indigent Patients," the following should be considered:

1. Before attempting an appeal to governmental authorities for aid you should know:

(a) Your state and local law with regard to hospital aid from tax sources.

(b) Has your city or county reached its debt limit? Can that debt limit be increased, or can borrowing outside of the debt limit be authorized?

(c) Can your city or state find a new source of tax revenue?

(d) Who is the proper authority to whom to appeal?

(e) Do you know the personal attitude of those in power toward hospitals?

(f) Who can wield the strongest political influence for you?

2. In presenting their case the hospitals must be able to prove their needs clearly, concisely and conclusively. Such arguments should be presented not only in writing, but graphically.

3. The taxpayers, particularly the organized groups of taxpayers, such as real estate boards, must be convinced of the increased need.

4. It helps the appeal if it is made by hospital presidents and trustees, who give their time and money, rather than by superintendents.

5. A strong newspaper and radio appeal should be organized.

6. The appeal should preferably be made by an official hospital organization. Politicians have great re-

spect for organizations as distinguished from individuals.

7. Someone must be responsible to see that all the elements of the campaign function at the right time and that the public interest in the matter is not allowed to die.

8. We should not overdo the appeal for tax support and thereby injure our charitable appeal.

"The above points were not all mentioned specifically, but they represent the fundamental ideas that were presented for consideration," added Mr. Wickenden.

Some Sources of Economies

One discussion at the A. H. A. 1932 meeting of the question of relief for personnel on vacations developed that some institutions were replacing absent supervisors with senior nurses, except in special departments or where greater responsibility and experience were required.

Several hospitals which have had long experience with central dressing and supply rooms urged that such departments saved so much in money, time, supplies and were productive of such general satisfaction that, as one man said, "a statement of the savings would be almost unbelievable."

A source of reduction of expense and of a slight increase in revenue mentioned by some superintendents was the revision of practices concerning free meals and a careful checking on the whole question of board and room. Several hospitals asserted that by discontinuing free meals to the staff and to certain personnel and substituting a schedule of fees, the hospital had not only derived a slight revenue, but what was more important, they had practically eliminated complaints.

PHILADELPHIA HOUSEKEEPERS

The first business meeting of the Philadelphia Chapter, National Executive Housekeepers Association, was held at the Adelphia Hotel September 15. Mrs. Oakes, president, presided. Those who took part included Amelia Vossen, secretary; Ellen Morley, chairman of the board; Doris Dungan, vice-president; Margaret Barnes, New York, past president of the national organization; Ann Owens, newly elected president; Adele Frey, Cleveland, Miss Dougherty, Seaside House, and Miss Brennan, Ambassador Hotel, Atlantic City.



COMMUNITY RELATIONS

How One Hospital Answers, and Reduces Complaints of Patients

Day and Night Supervisors Note Replies to Questions Concerning Service, and Suggestions; Letter to Discharged Patients Found to Be Productive of Good Will, Too

By S. CHESTER FAZIO

Superintendent, Rockaway Beach Hospital, Rockaway Beach, N. Y.

ACCORDING to the minimum standard of the American College of Surgeons, the medical staff of a hospital must hold a monthly meeting regarding discharged patients. At such time the treatment in certain difficult cases, other matters relating to the patients, and the results of the autopsies performed, are discussed scientifically. Most physicians welcome this opportunity to assist in advancing medical science in general, to make suggestions that they may be of benefit to the hospital, and to obtain information which may be applicable to their own cases.

In order that the hospital may best serve the patient, the board of directors of the Rockaway Beach Hospital also holds a monthly meeting to discuss the hospital routine, and in connection therewith any complaints that may have been entered or suggestions that may have been offered by the patients. The board has two means of ascertaining the latter data, which will be detailed herein.

A few years ago the hospital found itself occasionally confronted with an unpleasant situation due to the fact that in some instances a patient might make no complaint to the hospital personally but would complain to the attending physician regarding food, service, or some other matter of annoyance. As the physician had recommended or at least suggested the hospital, it appeared to the patient as if he were partly responsible for the discomfort endured. The physician, primarily with the welfare of his patient in mind but also motivated by the personal reason of satisfying his clientele, sought an explanation from the hospital.

It was difficult for the hospital administrator to convince the physician that insofar as he knew everything had been done for the comfort of the patient. The physician had the contention of his patient to the contrary, and although the supervisors had inquired daily of the patient as to his or her comfort and had made such adjustments as were advisable or possible, apparently to the satisfaction of the patient, there was no record of the patient's replies to these inquiries.

The resulting situation between the physician and the hospital administrators would, therefore, be somewhat strained at times. The physician was at a loss because in this community, as in many suburban communities, there was no other hospital in the near vicinity to which to send his patients when hospitalization was necessary. The physician needed the services of the hospital for his patients, but could not have them displeased with those services. The physician was dissatisfied with the care given, and further, the patient would undoubtedly voice this disapproval of the hospital to others. The hospital needed the support of the physician and the good will of the patient.

For the benefit of all concerned it was decided to institute the following method:

The day supervisor on her daily rounds inquires of each patient whether private, ward or charity, as to his or her comfort, as previously done. But now upon leaving the room the supervisor makes a notation of the answer of each patient, i.e., satisfied, a suggestion, or a complaint. A written report of these replies is then sent to the superintendent

to keep on file. The night supervisor follows the same procedure.

In this way the patients have an opportunity twice daily to report any matter which may disturb them, and the hospital has a chance immediately to adjust the situation.

It was realized also that patients do not like to report any matter which reflects upon the nurse. If they are considerate they do not like to think that the nurse may be reprimanded for something which may not be entirely her fault. In other cases they seem to fear that the nurse may be less agreeable or attentive for the remainder of their stay in the hospital. By this double inquiry it has been found that the patients are apt to report something occurring during the day to the night supervisor, feeling that she will attend to the matter without directly implicating or reprimanding the day nurse; and for the same reason a complaint regarding the night service is likely to be mentioned to the day supervisor.

It sometimes happens that due to the strain of being away from home, perhaps in pain or a highly nervous condition, an incident which was reported and apparently righted may reoccur to the patient's mind in a day or two in magnified importance and be related to the physician with unconscious exaggeration. This may not happen until the patient has returned home. In either case the two daily reports of the replies and comments of the patient during his or her entire hospitalization are shown the physician. These reports do much to prevent misunderstandings between the physicians and the hospital staff.

Occasionally the patients do not mention the matter to the physician,

but do to relatives and friends. Their opinion of the hospital is conveyed about town by gossip until someone connected with the hospital is finally made aware of it. The urban hospital, unless the matter is a vitally serious one, is less frequently affected in this way as the majority of the residents of a given locality in a city are generally unacquainted so that there is little exchange of opinions concerning a particular institution. But in a suburban community many of the people are acquainted, and as the hospital is entirely dependent upon the good will and contributions of the residents of that district, it cannot afford to permit unjustified, derogatory comment without an effort to correct the adverse impression.

The written daily reports have proved effective to a degree even in this regard. Upon hearing of the dissatisfaction of a patient, a letter is sent or a telephone call or a personal visit is made, inquiring as to the exact nature of the complaint. Upon reference to the reports and stating to the patient just what did occur, the disparity between his or her present attitude and that while in the hospital becomes apparent. The patient has not infrequently been surprised to find that the incident had become confused in his or her mind or that due to the weakness of illness only the part unpleasant in nature had made an impression which was retained. These patients generally cease to feel any animosity toward the hospital and have often admitted their error to their friends. Even the patients not particularly regretful of the possible detrimental result to the hospital of their remarks and who make no effort to contradict them, usually cease spreading any additional adverse comment.

However, it was discovered by some of these interviews with patients after leaving the hospital that despite the effort to make it as easy as possible for them to do so, some patients did not care to and would not express their opinions while in the hospital. The board of directors decided, therefore, that in fairness to the patients another opportunity should be afforded them to report any matter they desired regarding their stay in the hospital, and this time directly to the board of directors. Accordingly the following procedure was adopted:

Four or five days after a patient is discharged a letter is sent by the board to the patient's home and the recipient advised that the reply will

be considered confidential by the board. The form of letter sent is reproduced herewith.

It is now some days since you left the hospital but our interest in your welfare has not ceased.

We hope you have gained considerably through our hospital service and that your improvement will be steady and your recovery rapid and complete.

Our hospital strives always to render helpful and sympathetic service. We will be glad to hear how you have progressed and also will welcome any suggestions you may have regarding our work.

PRESIDENT, BOARD OF DIRECTORS.

The following suggestions accompany this letter, appearing on the third page of the four-page leaflet:

The board of directors of this institution will appreciate a statement from you, containing such criticism or comments as you may desire to make. It is understood that the statements on this sheet are confidential and are not to be disclosed (if at all critical) without the express consent of the patient making them.

Was the food good, well served and sufficient in amount?

If not, please specify.

Was the nursing service satisfactory?

If not, please specify.

Was your treatment by the office and supervisory staff, and by other employees, courteous and considerate?

If not, please specify.

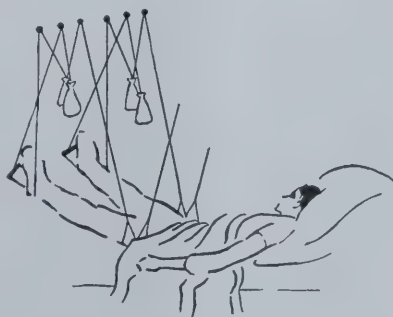
What general comment or statement have you to make?

Date

Signature

There is about a 35 per cent reply to these letters, the majority of which are from ward cases, as the private room patients often have special nurses and are not as much affected by the general routine.

There have been few complaints received in response to these inquiries, for when at home the patients seem to regain a more normal attitude of mind and are better able to view conditions as they actually were during their stay in the hospital. Inasmuch as any adjustments that could be made were effected while the patient was in the hospital, if then mentioned, most answers to the various questions are a sincere "satisfactory." The suggestions of-



ferred have been minor ones, such as that the linens should be a different color, or quite impractical ones such that in the maternity wards the babies should be with the mothers. Nevertheless any complaint is thoroughly investigated and each suggestion is given due consideration, as there is always the possibility that some may prove of value if modified or adapted to the conditions necessary in hospital procedure.

In this way the hospital feels it can continually endeavor to improve its service in accordance with the procedure as advocated by the patients themselves. As this attitude of the hospital is known throughout the town, persons who find they must spend time in the hospital and their families are saved considerable anxiety as to the treatment they may be accorded.

Quite often a donation accompanies the reply, sometimes only a dollar, but showing the appreciation of the patient to the best of his or her financial ability. More often the patient adds a word of appreciation for the care accorded by the hospital and for the interest as evinced by the follow-up letter. Many such letters have been received by the hospital before this letter has been sent, which, of course, is highly gratifying and encouraging.

MR. RATHJE DEAD

William J. Rathje, who for 27 years was president of the Englewood Hospital, Chicago, died September 22. "Those who knew him loved him, and will miss the devoted and unselfish service he always gave to the advancement of hospitals and community affairs in general," said a friend of the hospital concerning him. "He never failed to respond to a worthy cause and was always the first to contribute to the relief of the distressed individual or group of individuals." Mr. Rathje ranked among Chicago's most prominent and successful business men. His long career in the hospital field reflects credit on thousands of other trustees of American hospitals. In all his utterances, public and private, was to be found a keynote of a personality that was first and always practical, but was also endowed with a deep love of people."

SEES PRESIDENT HOOVER

Dr. J. L. McElroy, superintendent, hospital division, Medical College of Virginia, Richmond, Va., recently had a conference with President Hoover regarding the attitude of the American Hospital Association in respect to the government's hospital program. He pointed out to the president that there were a large number of vacant beds in approved hospitals available, and suggested that the American Hospital Association believes that the use of these will be just as convenient and as valuable to veterans as will be other hospitalization in rather distant government institutions. According to Dr. McElroy, President Hoover promised to make a study of the situation.

Superintendents in Many States Use These Newspaper Articles Weekly

Hospital Insurance Getting Consideration

(Week of October 17)

At the recent convention of hospital executives of the United States and Canada one big topic of conversation was the feasibility of providing for the payment of bills for hospital service under an insurance plan. A few hospitals in the southwest reported that such a plan was in operation and many hospital managers who listened to discussions and reports of the various insurance plans announced that they were going to try to work out some program.

"The interest in this subject proves the desire of the hospitals to help patients pay their way," explained (name), superintendent of Hospital. "Present economic conditions have worked a tremendous hardship on hospitals, markedly reducing the number of pay patients and increasing the number of free and part-free patients to an even greater degree. Moreover, donations from the public, upon which some hospitals could depend in the past to help pay the cost of caring for the free and part-free patients, now have almost stopped. So, many hospitals are trying to make a study of insurance schemes in order to make such a plan available if possible."

Hospitals Seek Fair Rate for County Patients

(Week of October 24)

A fair rate for service rendered by hospitals to patients for whose care a town, city or county is responsible is being urged by hospital leaders in many parts of the country, according to (name), superintendent of (name) Hospital. In some instances, the authorities are agreeing to a fair charge, because they have had a new realization of the cost of hospital service now that dwindling tax funds and other income have made officials of cities, counties and townships make a more careful study of charges that are being made to them for various services and products.

In this connection, with hospitals maintained by various units of government, such as the cities and coun-

Here is another group of newspaper articles for hospitals. Make as many copies of each article as there are newspapers, daily or weekly, club and church and other periodicals in your area, and send a copy to each editor at the time suggested. Be sure to fill in your name, and to add any facts or figures that you may have to show further the interest of your hospital in the subject discussed. Hospitals in many states are regularly using these articles and report great success with them. Please send clippings from your local papers to HOSPITAL MANAGEMENT.

ties mentioned, being overburdened with free patients, hospitals maintained by non-government agencies are being used by counties and cities as never before to care for indigent patients, Superintendent has been informed. It is the contention of the leading hospital authorities that, when a real study of the type of care given to patients is made, that the cities and counties will realize that they cannot build and maintain new hospitals nearly as economically as they can have indigent patients cared for in existing hospitals. This realization has had its effect in bringing the city and county authorities to agree to pay a fair rate to the non-government hospitals.

Hospitals Serve 12,000 More Daily; Income Less

(Week of October 31)

Discussing business conditions, as every one is doing these days, (name), superintendent, (name) Hospital, yesterday graphically pictured the terrific handicaps under which hospitals are laboring.

"Suppose a group of merchants in this country had every customer which they had last year and an average of 12,000 new ones a day in addition," said the superintendent. "But suppose that instead of paying proportionately for the materials and supplies purchased, which, of course, would be greater than when

there were fewer customers, suppose that these 12,000 additional customers and all the old customers, too, paid about 30 per cent less than what last year's customers paid. Transferring this thought to the hospital field, the hospitals of this country have about 12,000 more patients in their beds every day this year than they had last year, but all these patients are paying about one-third less than they paid in 1931. This statement shows better than anything else the handicaps many hospitals are facing in the way of increased demand for service, with fewer patients paying even a part of their bills."

Hospitals do not turn patients away, in spite of this condition, as long as they have funds with which to buy food and necessary service, added the superintendent, but many hospitals are finding it increasingly difficult to carry on unless public spirited citizens come to their aid and also unless every patient pay what he can for care received.

Hospital's Value Goes Beyond Its Own Walls

(Week of November 7)

Many people seem to think that the value of a hospital extends only to those who happen to receive treatment in its beds. Such is an extremely erroneous impression, (name) superintendent of (name) Hospital, said yesterday. The number of patients cared for is only one indication of the value of a hospital, for the community with a progressive hospital has an agency that helps its ethical and competent physicians to keep abreast of the times and to provide the newest methods of care and treatment of all their patients. As every one knows, only a small proportion of a physician's patients are cared for in a hospital; many more are advised and treated in the doctor's office or in the patients' homes. To these patients, as well as to those who are cared for in the hospital beds, the hospital is a blessing and a definite agency for good, since by helping the doctor to keep abreast of new ideas and methods and by providing him with new equipment, etc., the hospital thus makes possible better care for all the sick of the community.

How Highland Park Hospital Reduced Nursery Infection

Present Method of Treatment Decreased Cases of Impetigo
From 56 in One Year to 11 in Nearly Three Years

By CHESTER A. DOTY, M. S., M. D.

Department of Dermatology, Highland Park General Hospital, Highland Park, Mich.

IMPETIGO contagiosa, first described by Tilbury Fox in 1864, is a communicable skin infection most frequently seen in the new-born in nurseries. Many authors, including Ormsby, Sutton, MacLeod, and Stelwagon, classify this disease as synonymous with pemphigus neonatorum, while others consider it an entirely different skin infection.

The lesions of impetigo may resemble the pustular type of eczema. They are usually discreet and begin as small thin-walled vesicles and bullae on a mildly hyperemic base, which quickly become pustular. They may rupture or dry down, forming a crust.

As an etiologic agent some authors of text books (Highman, MacLeod) believe the streptococcus is the only cause of the infection, while others seem to believe that the staphylococcus is the sole cause. Howland and Holt believe that the staphylococcus is the most common cause, but that the streptococcus is sometimes involved also. I have had occasion to verify this. Falls, however, believes the causative agent to be a specific strain of staphylococcus aureus of variable virulence, which may be derived from a furuncle or acne of the skin.

If we accept this view, impetigo becomes a disease transmitted through hand contact with infected skin conditions or materials. Infection may come from a large number of sources, namely, the physician, the nurse and hospital attendants, as well as the parents and visitors.

In the Highland Park General Hospital an epidemic occurred during December, 1929. Sporadic cases had appeared in the nursery during part of the year, gradually increasing in number until December. In October with 76 births, 4 cases of impetigo were noted; in November, 82 births, 6 cases of impetigo; in December, 84 births, 36 cases of impetigo; in January, 1930, 83 births, 4 cases of im-

petigo; February, 73 births, no impetigo.

It will be noted from the accompanying table that during January, 1930, there were four cases of impetigo. These cases were "carry overs" from the epidemic of December. A different method of treatment was instituted about December 25, 1929, and following its use it may be seen that favorable results occurred. Our present treatment has varied slightly from that first employed in January, 1930, but in the main its principle is in use, namely, considering impetigo as a contact disease, contagious in nature.

About December 24, 1929, at the peak of the epidemic, the speaker was called in consultation. A large number of babies, possibly 25 to 28, were found infected. Other cases developed throughout the next ten days, bringing the total infections for the month to nearly 40 cases. The lesions ranged from small pin-head vesicles on some infants to large blebs about the groin and buttocks on others. The largest number of infections were in the region of the neck. Two developed furuncles or boils

on the scalp which cleared up slowly. Infection of the buttocks and thighs occurred in only ten cases; while the axilla seemed to be the least susceptible, only eight instances of this sort being observed.

The average time for the infection to appear was on the third or fourth day. The lesion began with a red-ened inflammatory area in the middle of which a small vesicle would develop on about the fourth or fifth day. These enlarged rapidly, many of them coalescing and forming a bleb. The superficial skin appeared opaque, soon rupturing, leaving the corium or true skin exposed. These lesions are found to be autoinoculable.

BACTERIOLOGY. Culture made from a number of lesions in different babies showed staphylococcus aureus present. One case showed streptococcus and staphylococcus.

METHOD OR CONTROL. All infected babies were moved to a separate room and placed under strict contagious surveillance. The uninfected babies were moved to a second nursery and were examined three times daily. A third nursery was opened



Nursery of the Highland Park General Hospital.

Read before 1932 Michigan Hospital Association convention, Flint.



One of the delivery rooms of the Highland Park General Hospital.

for the babies born following the closing of the old nursery. These babies also were examined three times daily. A rigid quarantine of all the nurseries with operating room asepsis was instituted. Each attendant, physician and nurse used sterilized gowns while in the nurseries. All were required to dip their hands in a solution of 1:5000 bichloride of mercury on entering and again before leaving the rooms, and clean gowns were used upon entrance to the various nurseries. A special nurse was on duty in each nursery. Visiting physicians were excluded during the epidemic.

The walls of the old nursery were washed and painted; the beds were washed with 1:5000 bichloride of mercury and the floor was mopped with it. The whole room was thoroughly sterilized before new-born infants were again returned to it.

Since this epidemic this procedure is being followed:

PROPHYLAXIS. As soon as the delivery room care is rendered, the infant is taken to the nursery, where it is bathed with sterile mineral oil; name tags are placed on its back and arm. It is dressed and placed into a crib of its own. Children are viewed by relatives only through a glass window.

DAILY CARE. Soap and water bath (liquefied castile soap) followed by a rinse in 1:10000 bichloride of mercury is a part of the daily routine. Sponge baths are given all babies until the cord is entirely healed; thereafter they are given tub baths. At the time of the bath they are all examined closely for any evidence of skin rashes. They are carried out to nurse at the regular feeding times on a large cart on which is a washable pad. This

pad is disinfected with 1:3000 bichloride of mercury before babies are taken to nurse and again when they are returned after feeding. The infants are wrapped and placed on the cart so that they do not touch one another. Upon returning they are again placed in their individual cribs. Any baby developing any type of a skin condition is immediately isolated and carried out to the mother by a nurse who wears a gown used only for this case.

CARE OF MOTHER'S BREAST. The nipple is washed with 50 per cent alcohol, followed by borax solution before feeding. After feeding it is again washed with borax followed by alcohol, and covered with sterile dressing until feeding time again.

PREVENTION is an important item. With this in mind, prophylaxis becomes an item of great importance. We feel that education of those in charge of the new-born to the fact that impetigo is a contagious disease transmitted by hand contact is of prime importance. To appreciate



fully the importance of this fact, all nurses should have completed their operating room training before being assigned to the nursery.

TREATMENT. No one but physicians and attending nurses, wearing sterile gowns, are permitted to enter the nursery. Immediately inside the door is a basin of 1:10000 bichloride of mercury solution in which those entering (interns, visiting physicians and nurses) wash their hands before handling infants.

Any case of dermatitis is placed in the isolation room. Each new-born baby is closely watched for dermatitis during the first three days of life. If a reddened inflammatory patch appears, a wet alcohol dressing is applied for the first 24 hours. Most of the cases completely recover during this time. The infant then remains under observation in isolation for 48 hours longer; if no other lesions appear, it is placed back in the main nursery. If, however, a vesicle appears in the center of the erythematous patch, this is immediately ruptured and treated with 5 per cent silver nitrate and an alcohol dressing applied.

The treatment used in the early part of our epidemic at Highland Park General Hospital consisted of the following operations:

(1) Breaking all vesicles and blebs and applying 5 per cent silver nitrate.

(2) Applying 3 per cent ammoniated mercury ointment over a greater part of the body as well as over the infected parts.

To our astonishment, it was observed that new vesicles appeared in those areas treated with mercury ointment; in some cases in nearly as large numbers as elsewhere. Further, that normal areas which had been treated with the ointment became more susceptible to abrasions than untreated areas. This observation led to the early abandonment of all ointments for the following reasons:

First, we believed that greases and ointments form a coating over the epidermis, and not coming in direct contact with all organisms, in a sense, seem to protect rather than destroy the invading bacteria.

Secondly, that the epidermis of the new-born is not as fully developed as the adult skin, for which reason it responds to the action of greases, becomes softer (possibly simulating the soft skin of the premature) and, consequently, may be more easily abraded. Our conclusions were that ointments were contra-indicated, and that the infant skin required hardening rather than softening. This, then,

is the principle that was followed in subsequent treatments, and we feel that results were sufficiently satisfactory to justify our passing the advice on to our hospital neighbors:

(1) A dip in bichloride of mercury 1:5000 or 1:10000 following the bath serves the double purpose of coagulating bacteria and hardening the skin. Nut-gall solution may be used equally well for the hardening effect, but it has a weaker germicidal action.

(2) Application of alcohol dressing to any erythemas (hardening again).

(3) Treatment of vesicles or blebs by 5 per cent silver nitrate (also hardening).

The speaker realizes that this contribution represents an old method with a modification of some phases of the therapeutic principle involved. Its application, however, has practically eliminated impetigo as an epidemic from our nursery. It is difficult to eliminate the sporadic case which is probably due to a slight break in technique or to infected milk of the mother. Mellon, Caldwell, and Winan, in 1925, traced the source of several nursery outbreaks to staphylococcus in the mother's milk. At the Highland Park General Hospital, during the epidemic, five babies were born with the most rigid technique relative to sepsis exercised by our obstetrical department. Notwithstanding the extra precaution, two of the five infants developed impetigo lesions on the second and third days of life.

Our methods have withstood severe tests for the past two years, inasmuch as our visiting hours at one period of the day overlap the feeding hour. No amount of effort will prevent visitors from handling the new-born during this period. The change of visiting hours has been attempted; however, in a municipal hospital such as ours, difficulties have been encountered. In July, 1931, four cases appeared which were directly traceable to contact with infected visitors. The above technique proved its worth in checking these cases.

The expense is small, which is an important item. The method is efficient when carried out.

In the table, in August, 1932, four cases appear in the column under "pustules." In three of these cases the lesions were small, pinpoint, hard papules. Although they disappeared under treatment, they are reported under this heading. In one case, small soft pustules appeared containing a yellow serous fluid. The lesions were approximately 1/16 inch in diameter, simulating those one would see in a staphylococcal infection. These appeared on the neck and disappeared under treatment.

"Before and After"

Previous to Institution of Present Treatment

Month	Year	Births	Cases of impetigo	Pustules
March,	1929.....	102	1	..
April,	1929.....	92	..	..
May,	1929.....	89	1	..
June,	1929.....	93	2	1
July,	1929.....	104	5	13
August,	1929.....	91	1	2
September,	1929.....	71	..	..
October,	1929.....	76	4	5
November,	1929.....	82	6	3
December,	1929.....	84	36	3
Totals	.....	884	56	27

Following Use of Present Method of Treatment

Month	Year	Births	Cases of impetigo	Pustules
January,	1930.....	83	4	..
February,	1930.....	73	..	..
March,	1930.....	80	..	1
April,	1930.....	80	1	1
May,	1930.....	81	..	..
June,	1930.....	91	..	..
July,	1930.....	114	..	1
August,	1930.....	76	..	..
September,	1930.....	79	..	..
October,	1930.....	68	..	5
November,	1930.....	72	1	2
December,	1930.....	56	..	..
January,	1931.....	85	..	..
February,	1931.....	71	..	..
March,	1931.....	49	..	..
April,	1931.....	75	..	..
May,	1931.....	62	..	..
June,	1931.....	64	..	8
July,	1931.....	70	4*	..
August,	1931.....	68	..	..
September,	1931.....	63	..	..
October,	1931.....	47	..	..
November,	1931.....	46	..	1
December,	1931.....	57	..	3
January,	1932.....	47	..	1
February,	1932.....	48	..	..
March,	1932.....	42	..	..
April,	1932.....	55	..	1
May,	1932.....	41	..	..
June,	1932.....	42	..	..
July,	1932.....	51	..	..
August,	1932.....	31	1	4
September,	1932.....	42	..	..
Totals	.....	2,109	11	28

*Infected by visitors.

Above is a tabulation of cases of impetigo and pustules among newborn at Highland Park General Hospital. After January 1, 1930, the new method of attacking this problem was begun, with the success indicated by the above figures. This article gives details of the system which has been so successful in reducing infection in the nursery, a problem that occasionally confronts many hospital executives, and sometimes results in comprehensive and expensive changes in the department, without result.

The nursery at this time was under the care of student nurses.

All lesions appearing on the skin, some pinpoint papules, others small pustules, are reported in this article under the heading of "pustules." Many of these lesions are pinpoint in size and have disappeared without treatment.

The above facts are the results of observations made during our epidemic. This paper has been prepared at the suggestion of the superintendent and management of the Highland Park General Hospital, who have been favorably impressed with the results obtained in these cases.

Bibliographies consulted: Reed; Chadwell; Swendon & Lee.

A. D. A. Announces Annual List of Approved Hospitals

THE American Dietetic Association recently announced its approved list of hospitals giving acceptable courses for dietitians, the list comprising institutions which had been inspected by representatives of the association up to August 15.

Inspectors who visited the hospitals seeking approval and who make a personal survey of the institution with special reference to its facilities for training student dietitians included the following:

Mary Northrop, Elizabeth Baldwin, Angeline Phillips, Helen B. Thompson, Florence Armstrong, Emily Timlow, Mary DeG. Bryan, Emma Feeney, Martha Koehne, Evelyn Smith, Phyllis D. Rowe, M. Faith McAuley, Louise Gilbert, Alberta Childs, Marjorie Copher, Ruth C. Baumhoff, Mary Beeman, Fern Gleiser, Marie Mount, Mary Diefenderfer, Quindara O. Dodge, Helen Clarke, Rosina Vance, Genevieve Cartmill, Bess Whittaker, Alta Atkinson, Margaret Mills, Kate Daum, Alice Biester, Frances Dunning, Mary Harrington, Bertha Bisbey, Margaret Fedde, Lenna Cooper, Nelda Ross, Blanche Shaffer, Kathleen Lewis, Ruth Senteff, Ethel Thompson, Florence Bateson, Alice Hoover, June Kennedy, Jessamine Williams, Melissa Hunter, Laura Drummond, Grace Godfrey, Marjorie Bacheller, Rena Eckman, Pauline Sanders, Georgia Newsom, Effie Raitt, Jennie Rowntree, Frances Kirkpatrick, Lu-rena Perrine.

The list of courses approved and the hospitals in which they are given, together with the dietitian in charge of the course, is as follows:

Canada:

Vancouver General, Vancouver, B. C., Ethel C. Pipes.
^aUniversity of Alberta Hospital, Edmonton, Alberta, Margaret Malone.

California:

^aScripps Metabolic Clinic, La Jolla, San Diego, Helen B. Anderson.
 Stanford University Hospital, San Francisco, Charlotte Sloan.
^aCottage Hospital, Santa Barbara, Wilda Nylen.

^aNine month course. ^bOne year course. ^cSix month course.

Hospitals with no notation have eight month course.

¹Eight months, 1 year optional.

²One year minimum; graduates of accredited courses who are especially interested in administration are given preference in appointments.

³One year; post-graduate course in food clinic also offered.

⁴Eight months; post-graduate course in food clinic also offered.

Alameda County Hospital.
 Highland Hospital, Mattie E. Stover.
 Fairmont Hospital, Oakland, Leone Hampton.

Connecticut:

Waterbury Hospital, Waterbury, Elizabeth Bryant.

Georgia:

^bEmory University Hospital, Atlanta, Jessie Harriss.

Illinois:

Cook County Hospital, Chicago, Millie E. Kalsem.
^bMichael Reese Hospital, Chicago, Katherine M. Thoma.
 St. Luke's Hospital, Chicago, Frances B. Floore.
 Wesley Memorial Hospital, Chicago, Elizabeth Tuft.

Indiana:

^bIndiana University Hospital, Indianapolis, Lute Troutt.
^cCity Hospital, Indianapolis, Amy Cole-scott.
^aMethodist Hospitals, Indianapolis, Margaret Marlowe.

Iowa:

^bUniversity Hospital, Iowa City, Kate Daum.

Maryland:

^bJohns Hopkins Hospital, Baltimore, Phyllis D. Rowe.

Massachusetts:

Beth Israel Hospital, Boston, Maniza Moore.
 Boston City Hospital, Boston, Margaret McGovern.
 Children's Hospital, Boston, Martha Stuart.
 Massachusetts General, Boston, Marion Floyd.
 Peter Bent Brigham, Boston, Gertrude McDonald.

Michigan:

Harper Hospital, Detroit, Mary M. Harrington.
 Henry Ford Hospital, Detroit, Ruth Smithyman.
^bUniversity Hospital, Ann Arbor, Dorothy S. Waller.

Minnesota:

Ancker Hospital, St. Paul, Winifred H. Erickson.
 Minneapolis General, Minneapolis, Ethel Gough.
 Swedish Hospital, Minneapolis, Ethyl Clemens.
 University Hospital, Minneapolis, Gertrude Thomas.
¹St. Mary's Hospital, Rochester, Sr. Mary Victor.

Missouri:

Barnes Hospital, St. Louis, Edith Tilton.
 Research Hospital, Kansas City, Ethel Ollis.

Nebraska:

Lincoln General, Lincoln, Leta Linch.

New York:

Albany Hospital, Albany, Virginia H. Ray.
 Buffalo City Hospital, Buffalo, Ursula Senn.
 Fifth Avenue Hospital, New York City, Mabel Supplee.
 Montefiore Hospital, New York City, Lenna Cooper.
²Mt. Sinai Hospital, New York City, Adeline Wood.
^bPresbyterian Hospital, New York City, Nelda Ross.
^cRochester General, Rochester, Effie Winger.
^cStrong Memorial, Rochester, Grace Carden.
^bGrasslands Hospital, Valhalla, Rhoda Tyler.
 St. John's Hospital, Brooklyn, Eloise McCreery.

North Carolina:

^aWatts Hospital, Durham, Margaret Fitzhugh.
^bDuke University Hospital, Durham, Elsie Wilson Martin.

Ohio:

Cincinnati General, Cincinnati, Gertrude Lauche.
 Mt. Sinai Hospital, Cleveland, Helen Mallory.
 Starling-Loving, Columbus, Mary Louise Bone.
^bMiami Valley Hospital, Dayton, Alta B. Hirsch.

Oklahoma:

University Hospital, Oklahoma City, Margery Ardrey.

Oregon:

Portland Dietitian Training Course:
 Multnomah County Hospital, Edna B. Carl.
 Good Samaritan Hospital, Elizabeth Stewart.
 Doernbecher Hospital, Dorothy J. Keane.

Pennsylvania:

^aPennsylvania Hospital, Philadelphia, Helen E. Gilson.
⁴Philadelphia General, Philadelphia, Elizabeth Miller.
 Homeopathic Hospital, Pittsburgh, Irene Willson.
 Western Pennsylvania, Pittsburgh, Charlotte Addison.

Tennessee:

Vanderbilt University Hospital, Nashville, Salome Winckler.

Utah:

Latter Day Saints, Salt Lake City, Katherine Bielby.

Virginia:

^aMedical College of Virginia, Richmond, Aileen Brown.

Washington:

^aWashington State Intern Training Course, Seattle:
 Seattle General Hospital, Evelyn Engdahl.
 Swedish Hospital, Ruth Forsberg.
 Virginia-Mason Hospital, Louise Powley.
^aHarborview Hospital, Mary Northrop.
 Washington, D. C.
^bWalter Reed General Hospital, Grace H. Hunter.



WHO'S WHO IN HOSPITALS

JOHAN R. SMILEY, superintendent, St. Luke's Hospital, Kansas City, Mo., soon will give active thought toward making the 1933 convention of the Midwest Hospital Association an outstanding success. He was named president-elect of this group last year, and became president at the conclusion of the highly successful 1932 meeting which was presided over by Miss E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis. Mr. Smiley has been in charge of St. Luke's since June 1, 1923, entering hospital work from service in the U. S. Veterans' Bureau. He had been training officer and office manager of the Kansas City office of the Bureau for two years before going to St. Luke's. Mr. Smiley returned from overseas with the rank of captain and was overseas 18 months. After working his way through William Jewell College, Mr. Smiley served for a time as deputy county clerk of Clay County and for two years as assistant cashier of a bank in Liberty, Mo. Mr. Smiley wants to make his term of president memorable for the excellence of the convention program and the attendance at the 1933 meeting and plans to start work to this end within a very short time.

E. C. Moeller, business manager of Lutheran Hospital, Fort Wayne, Ind., recently spoke before the local Exchange Club on a hospital's relations to its community.

Sister Stella, formerly superintendent of St. Thomas Hospital, Nashville, Tenn., now is superintendent of St. Joseph's Hospital, Chicago, succeeding Sister Stephanie.

Alice Lukkarila has been appointed instructress of nurses at City Hospital, Alliance, O., to succeed Ruth Binder, who resigned, and Geneva Casey is now maternity ward supervisor, succeeding Goldie West.

Sister Virginia, R. N., B. S., formerly superintendent of St. Agnes Hospital, Fresno, Calif., is now superintendent of St. Joseph's Hospital, South Bend, Ind.

Lillian Olson is the new superintendent of McPherson Memorial Hospital, Howell, Mich.

Helen Langerman, formerly night superintendent, now is assistant superintendent of Easton Hospital, Easton, Pa.

Dr. Louis Dorpat, former health officer at Iron Mountain, Mich., is the new medical superintendent of

Southview Hospital, Milwaukee, Wis., an isolation institution.

Delia Newton is superintendent of nurses at Middlesex Hospital, Middletown, Conn.

Margaret Wolbold has succeeded Rhoda Barker as superintendent of Twin City Hospital, Dennison, Ohio.

Dr. H. W. McAdoo has succeeded Dr. E. P. Bledsoe as superintendent



JOHN R. SMILEY

Superintendent, St. Luke's Hospital,
Kansas City, Mo.

of Springfield State Hospital, Westminster, Md.

Laura Wells, for 17 years superintendent of nurses at St. Elizabeth's Hospital, Shanghai, China, recently visited Chicago on a vacation.

Minnie Harms is head nurse at the Auburn Hospital, Auburn, Neb.

Dr. J. E. Williams has opened a hospital in Doniphan, Mo.

Dr. H. L. Schilling has established a hospital in Platteville, Wis.

Flossie Beckdolt, superintendent of nurses of Community Hospital, Fremont, O., is taking a nine months' course in public health work at Ohio State University.

Mrs. Emma Tevis Foreman has been appointed librarian of Methodist Hospital, Indianapolis, and Timoxema Sloan has been appointed assistant director of nursing.

Mrs. Lillian Grace, formerly superintendent of Minneapolis Hospital, Minneapolis, Kan., is now superintendent of Community Hospital, Pratt, Kan.

Maxine Tews has been appointed

hospital librarian of the Rochester Minn., Public Library and the Mayo Clinic. Miss Tews is a graduate of the library school of the University of Minnesota.

Luella Adkins recently was named superintendent of nurses at Grace Hospital, Cleveland. She formerly was with Deaconess Hospital, Lincoln, Ill.

Kathryn Hinon has been appointed dietitian at City Hospital, Indianapolis.

Mrs. Lucy Johnson, formerly with Edwards Sanatorium, Naperville, Ill., has succeeded Mary Large as superintendent of Woodstock Hospital, Woodstock, Ill.

The Plymouth Hospital, Plymouth, Mich., has been opened with Lena Weist as superintendent.

Helen Bierman has been appointed superintendent of Witham Hospital, Lebanon, Ind.

Florence A. Ambler, formerly educational director, Philadelphia General Hospital, now is assistant superintendent of Samaritan Hospital, Troy, N. Y.

Edna S. Newman has been appointed acting dean of Cook County School of Nursing, Chicago, succeeding Laura R. Logan, who resigned. Miss Newman has been assistant dean since 1925.

Anna Weisenhorn, formerly instructor of nurses at St. Mary Hospital, Quincy, Ill., is in charge of the school of nursing at Glockner Sanatorium and Hospital, Colorado Springs, Colo.

Kathleen Grant is the new superintendent of Carney Hospital, Alma, Mich.

Esther Rehm, formerly assistant director of nursing in Blodgett Memorial Hospital, Grand Rapids, Mich., has been appointed superintendent of nurses.

The Greenfield, O., Hospital recently was opened, with Mrs. Florence Bobo and Violet Shields as head nurses.

Dr. W. D. Beadie, superintendent, Mineral Springs Sanatorium, Cannon Falls, Minn., gave an address to the Northfield Rotarians recently on the treatment of tuberculosis.

Sister Mary Avitus, formerly of St. Joseph's Mercy Hospital, Ann Arbor, Mich., is now in charge of St. Joseph's Mercy Hospital, Waverly, Iowa, succeeding Sister Mary Felicitas, who was transferred to Cresco.

15 Years Ago—THIS MONTH—10 Years Ago

From "Hospital Management," October 15, 1917

Six hundred registered at 1917 A. H. A. convention, Cleveland. Relations with the government, Red Cross, and similar agencies, in connection with war problems, occupied a great deal of the time of the convention.

Secretary Walsh's report showed that the A. H. A. had 1,149 active and 264 associate members.

President R. J. Wilson, in remarks, stated, "The hospitals of America are not the tail to the American Medical Association's kite."

Editorial urged superintendents, especially those with experience, to stay on the job and not enlist for war service, owing to the fact that there was an ample supply of executives available for military service and the supply for civil hospitals limited.

From "Hospital Management," October 15, 1922

Dr. MacEachern named president-elect, the first man ever to be nominated from the floor of the A. H. A. convention.

A. H. A. approved the report of the committee on the study of training hospital executives, which was financed by the Rockefeller Foundation.

HOSPITAL MANAGEMENT chartered car to Atlantic City convention.

Dr. C. S. Woods elected president of the American Protestant Hospital Association.

A. H. A. committee report on flooring created widespread comment with many disagreeing.

Hospital exhibitors organize association.

Association Brings Marked Progress to Physiotherapy

By CHARLOTTE MORRISON

SLOWLY and quietly this association is setting apart the profession of physiotherapy from the many drugless cults that have dragged at its skirts since its beginning until it has begun to take its place as a true medical adjunct, no less valuable to the medical field than are the registered nurse and the registered pharmacist.

Since its beginning it has ever aimed toward high standards in ethics, in education. It has ever carefully selected its members in regard to personality and background. Never content with the past year's standards of education or the past year's increase in membership, it pushes on, and after it come new schools offering more inclusive curricula of training, and recognition and cooperation from proven associations.

For the first time in its history, this association received an invitation from the American Medical Association to assist in a demonstration of the use of physiotherapy in the treatment of arthritis at their annual convention in New Orleans in May. Two delegates were sent to work under the direction of the Council on Physical Therapy of the American Medical Association and the Committee on the Control of Rheumatism.

At the eleventh annual convention of the American Physiotherapy Association held the last of June in Milwaukee not only the increased professional and commercial exhibits but

papers by such men as J. W. Powers, W. P. Blount, E. J. Carey, Harry Tabachnick, R. E. Brown, W. D. Stroval, W. J. Meek, and a symposium upon abdominal conditions and their treatment discussed by G. G. Deaver and Edmund Jacobson, Dr. F. J. Gaenslen's discussion of the Relation of Physical Therapy to Medicine and Surgery, and Dr. J. S. Coulter's exhibit of old prints, books and pictures depicting early history and uses of physiotherapy, show the search for reliable and stimulating scientific information in the field for physical therapy that its professional standards may be increasingly higher.

The reports showed five new schools accepted, the tendency of hospital courses to become more closely affiliated with medical schools and universities, and the submitting of tentative outlines and proposed changes to the Committee on Education for criticism and advice, the help and cooperation of the American Nurses' Association and the American Physical Education Association, the turning of State Boards of Medical Examiners to the association to see if an applicant's training is approved before they will grant a license.

Such are the aims and ambitions of the association and may its accomplishments show that of which its members are made.

Officers and executive committee of the American Physiotherapy Association, 1932-1933, are:

President, Miss Margaret S. Campbell, 950 East 59th Street, Chicago.

Vice-presidents, Miss Marion Swezey, Gary Hospital, Gary, Ind.; Miss Martha Hindman, 415 Hamm Building, St. Paul, Minn.

Treasurer, Miss Mable Holton, University Hospital, Ann Arbor, Mich.

Secretary, Miss Lillian Beckman, 7425 Harvard Avenue, Chicago, Ill.

Members-at-large, Miss Florence Phenix, Department of Public Instruction, Madison, Wis.; Miss Catherine Worthingham, 340 South 16th Street, San Jose, Cal.

Appointment Bureau, Miss Emily Griffin, Monmouth Memorial Hospital, Long Branch, N. J.

Chairman, Membership Committee, Miss Marion Swezey.

Chairman, Committee on Education, Miss Mildred Elson, 942 North Jackson Street, Milwaukee, Wis.

Chairman, Committee on Publicity, Miss Charlotte Morrison, 303 East Chicago Avenue, Chicago.

Chairman, Legislative Committee, Miss Mary E. Hibbler, 450 East 64th Street, New York.

NEW HOSPITAL SERVICE

Hospital Advisers, Inc., is the name of a new organization offering a varied service to the hospital field. The organization is headed by Ada Belle McCleery, superintendent, Evanston, Ill., Hospital; Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago; Alfred C. Meyer, president, Michael Reese Hospital, and Carl A. Erikson, of Schmidt, Garden & Erikson, architects, Chicago. "We offer an advisory service to hospitals," says the announcement. "We are prepared to review all the activities of an institution, or any part of these activities, and to make such suggestions and recommendations as a study, interpreted by our experience, may prompt."

Here's One Version of the 1932 Hospital Salary Schedule

A MUNICIPALLY controlled hospital in an eastern state recently announced the following salary schedule for the 104 positions in the administrative department. The institution has a total capacity of 260 beds, of which 150 were available as a new plant recently was opened.

In connection with the opening of the building there was a general revision of salaries, as may be seen from the following division payrolls, "present salaries" referring to the old building which had 115 beds.

Administrative division, minimum under ordinance, \$14,260; maximum, \$18,950; present salaries, \$22,320; new salaries, \$16,780.

Dietary division, minimum under ordinance, \$10,800; maximum, \$13,140; present salaries, \$9,600; new salaries, \$12,560.

Housekeeping division, minimum under ordinance, \$8,800; maximum, \$11,040; present salaries, \$7,020; new salaries, \$8,880.

Laundry division, minimum under ordinance, \$4,560; maximum, \$5,700; present salaries, \$6,120; new salaries, \$5,460.

Power plant division, minimum under ordinance, \$18,660; maximum, \$24,900; present salaries, \$5,520; new salaries, \$11,380.

Medical division, minimum under ordinance, \$5,940; maximum, \$9,060; present salaries, \$9,420; new salaries, \$8,900.

Nursing division, minimum under ordinance, \$18,840; maximum, \$21,480; present salaries, \$27,910; new salaries, \$23,100.

Total, minimum under ordinance, \$82,000; maximum, \$104,270; present salaries, \$87,900; new salaries, \$87,060.

Annual salaries paid different positions are as follows:

Administration division: Superintendent, \$5,000; bond \$5,000; meals.

Chief bookkeeper, \$1,200; bond, \$1,000; one meal.

Bookkeeper, \$840; one meal.

Admitting clerk, \$780; one meal.

Historian, \$1,000; one meal.

Telephone operators (3), \$540; one meal.

Clinic supervisor, \$1,200; maintenance.

Dispensary clerk, \$900; one meal; \$500 bond.

Secretary to superintendent, \$720; \$1,000 bond; one meal.

Clerk-stenographers (2), \$600; one meal.

Information clerk, \$720; one meal.

Cost clerk, \$600; one meal.

Storekeeper, \$1,000; one meal; bond, \$2,500.

Dietary division: Dietitian, \$1,680; maintenance.

Chef and baker, \$1,500; meals.

Assistant dietitian (2), \$1,000; maintenance.

Night cook, \$480; meals.

Second cook, \$720; meals.

Vegetable man, \$480; meals.

Kitchen porter (2), \$480; meals.

Dish washer, \$480; meals.

Kitchen maid (2), \$360; meals.

Dining room maid (3), \$420; meals.

Counter girl, \$600; meals.

Counter girl, \$420; meals.

Maid and dishwasher (2), \$420; meals.

Waitress, \$420; meals.

Housekeeping division: Housekeeper, \$660; maintenance; \$1,000 bond.

Seamstress (2), \$480; one meal.

Maid (6), \$420; one meal.

Porter (5), \$480; one meal.

Wall washer, \$480; one meal.

Wall washer, \$420; one meal.

Nurses' aid and ward helper (4), \$360; one meal.

Laundry division: Laundry manager, \$1,200; meals.

Laundress (6), \$480.

Laundress, \$540.

Wash man, \$840.

Power plant division: Chief engineer, \$3,000; meals.

First assistant engineer, \$1,750.

Second assistant engineer, \$1,500.

Third assistant engineer, \$1,500.

Power plant maintenance man, \$1,500.

Mechanic, \$1,050.

Elevator operator (3), \$360; one meal.

Medical division: Pathologist, \$2,400; \$1,000 bond; one meal.

Technician in laboratory, \$1,000; maintenance.

Pharmacist, \$1,200; \$1,000 bond; maintenance.

Intern (6), \$300; maintenance.

Technician in X-ray department, \$1,000; maintenance.

Anesthetist, \$1,500; maintenance.

Nursing division: Superintendent of nursing, \$1,620; \$1,000 bond; maintenance.

Instructor, \$1,500; maintenance.

Supervisor of operating rooms, \$1,500; maintenance.

Chief supervisor, \$1,500; maintenance.

Practical supervisor, \$1,020; maintenance.

Obstetrical supervisor, \$1,380; maintenance.

Pediatric supervisor, \$1,080; maintenance.

Night supervisor, \$1,200; maintenance.

Assistant night supervisor, \$900; maintenance.

Dispensary supervisor, \$1,080; \$1,000 bond; maintenance.

Assistant supervisor of operating rooms, \$900; maintenance.

Assistant supervisor of maternity cases, \$900; maintenance.

Assistant supervisor of surgery, \$900; maintenance.

Orderlies (4), \$600; one meal.

Nurses' aid, \$480; one meal.

House mother, \$840; maintenance; \$1,000 bond.

Medical supervisor, \$1,200; maintenance.



Assistant supervisor of emergency cases, \$900; maintenance.

Assistant supervisor of medical cases, \$900; maintenance.

Assistant supervisor of pediatrics, \$900; maintenance.

SIMPLIFY BEDS

The revision of simplified practice recommendation covering bedsteads, springs and mattresses has been accepted by all interests in the industry and is to be effective as of November 1, 1932, according to an announcement by the division of simplified practice of the Bureau of Standards.

This recommendation, which was proposed and developed by the industry, is concerned with the size, length and width of straight foot wood beds having wood or steel angle side rails; the size, length and width of straight foot metal beds having steel angle side rails, and the class, type, size, length and width of bed springs.

Heretofore it was recommended that mattresses be made to conform to the bed dimensions. There is now before the industry for approval a proposal to specify definitely the sizes of mattresses as 6 feet 1 inch long by 4 feet 4 inches, 3 feet 10 inches, 3 feet 1 inch, or 2 feet 10 inches. These widths are the same as those already selected for the top widths of the spiral or coil wire springs.

NURSING CALENDAR

This year the Publications Committee of the National League of Nursing Education is presenting a hanging calendar of quotations which will make an appropriate gift for every one. The title is "Quo Vadis?" and within its pages will be found quotations from some modern educators and philosophers, such as Whithead, Dimmet, Lippmann, Dewey, and others. Interspersed here and there will be found quotations from some of the old writers, which are just as modern as though they were written today. The cover page is from a painting by H. Willard Ortlip, who painted the beautiful cover page for the Florence Nightingale Calendar. The majestic beauty of the picture will be a source of pleasure to any one who buys it. The calendar is arranged with two weeks on each page. The price is \$1 per single copy, and 75 cents per copy on all orders of fifty or more, delivered in one shipment. Address N. L. N. E., 450 Seventh Avenue, New York.

URGES GRADUATE NURSING

The Hospital Association of West Virginia at its 1932 meeting passed a resolution that small hospitals make a careful study to see if the replacement of student nurses by graduates would not be more satisfactory all around. Another resolution placed the association in opposition to further construction of government hospitals, and in favor of the hospitalization of veterans in hospitals of their own choice. Paul H. Fesler, Wesley Memorial Hospital, Chicago, as president, represented the American Hospital Association. Other speakers included Dr. W. E. Vest, Huntington, president; Dr. Albert Hoge, Bluefield, president, State Medical Association; Dr. A. G. Rutherford Welch, incoming president; C. F. Runyon, Charleston; Dr. Edward C. Armbrecht, D. D. S., Wheeling; Mrs. Kathryn Trent, president, State Nurses' Association; Dr. Ward Wylie, Mullens; Dr. R. O. Rogers, Bluefield. Joe W. Savage, Charleston, is executive secretary of the association.

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This clear-cut and emphatic statement by the American Hospital Association is especially welcome at this time when even those hospital superintendents who in the past did not feel that the support of the public was of sufficient importance to justify a systematic effort to obtain it, now are turning to any project which promises to increase the interest and cooperation of the community.

HOSPITAL MANAGEMENT is especially pleased to note this stand of the American Hospital Association, for from its very establishment this magazine has encouraged educational efforts on the part of hospitals. National Hospital Day, launched and developed to international success by HOSPITAL MANAGEMENT, was the first contribution of the journal to help hospitals throughout the field in a practical way to obtain public attention and support. Seven years ago HOSPITAL MANAGEMENT started the publication of bulletins for hospitals as a means of offering the majority of hospitals an ethical, effective, economical and highly convenient means of regular contact with wealthy and influential people in their communities. Later came the Community Relations department every month. More recently HOSPITAL MANAGEMENT began the publication of articles for local newspapers, which may be used by many hospitals merely by filling in local figures and information. Papers for nursing schools, an interesting and prestige-building extra-curricular activity for student nurses, are the latest practical contribution of HOSPITAL MANAGEMENT to assist hospitals in a dignified and result-producing educational campaign.

It is interesting to note that National Hospital Day, hospital bulletins and local newspaper articles all were referred to and recommended by the American Hospital Association Committee on Public Relations, the chairman of which was Dr. MacEachern.

It goes without saying that this report deserves the careful perusal of every progressive superintendent, and while the program suggested may seem idealistic in some places, yet the report represents the most comprehensive and practical contribution to this subject ever made by an A. H. A. committee. Moreover, as these lines show, the average hospital can economically, conveniently and effectively adopt a number of the suggestions of this report. As a matter of fact, a number of hospitals are regularly using these forms of educational effort, with marked success.

There is one point which must be stressed, and that is, that in the last analysis, each hospital must win its own friends and gain its own support. To do this, it must act individually. It must pioneer and suffer some of the antagonism and ill-feeling that often attach to people who try new things. All the printed reports in the world, all the committees and all the resolutions will not gain one friend or bring one cent in donations to a hospital if that hospital does not act to help itself.

So one of the results of this latest A. H. A. report on public education ought to be to influence hospitals to act, to publish bulletins, to make use of newspaper articles and to do the other things outlined and recommended in the report.

Texas Hospitals Pioneer in Insurance

The leading article in this issue deals with hospital insurance, a subject that, judging by the interest shown at the recent American Hospital Association convention in Detroit, is one of the liveliest before the field today. HOSPITAL MANAGEMENT in the past has given space to

Hospitals Must Educate Public, Says A. H. A.

"Hospitals must adopt a plan of public education.

"They must utilize every possible means of disseminating information about themselves."

These statements from the 1932 report of the A. H. A. committee on public relations forcibly present the position of the American Hospital Association on the question of educational programs by hospitals.

It will be noted that the committee did not waste much time discussing the ethics of such a program, nor did it merely say that an educational program was desirable. "Hospitals must adopt a plan of public education," was the statement.

descriptions of various plans for paying hospital bills by the insurance method, but practically all of these schemes depended for success on certain local conditions which would not be widely duplicated..

The plan which hospitals of San Antonio and Houston are using, however, seems to offer possibilities of more widespread adaptation, and the details of the Houston plan, as outlined by Mr. Jolly, deserve careful study by anyone interested. Hospital insurance is a comparatively new project, generally speaking, and the development of the plans in San Antonio and in Houston, in which a number of local hospitals cooperate, may be one solution of the problem of helping the average patient pay his hospital bill.

That the insurance plan of paying for hospital service is practical is intimated by successful experience of a number of hospitals.. Many superintendents and others who would like to see some plan in effect, with their own institution cooperating, however, have felt that local conditions have played a very important if not an essential part in the plans they have investigated. One hospital, for instance, may have a full time medical staff, another a close tie-up with a large industry, another the benefit of a special endowment. Until the Texas projects were carried on, therefore, many felt that they could not possibly hope to establish an insurance scheme.

The Texas hospitals, however, seem to have been able to pioneer and to smooth out wrinkles and rough spots, and a number of the Texas plans are considered beyond the experimental stage by the hospitals involved. Some of these plans, as Mr. Jolly points out, may be further improved from the standpoint of the patient and the hospital.

At any rate, the wideawake hospital superintendent ought to be familiar with the various features of the Texas plans, and Mr. Jolly's article gives an outline based not only on close study and observation, but an outline written by a man who believes in hospital insurance so strongly that he and his co-workers in Houston actually are launching such a program.

There is one question which immediately suggests itself when a discussion of hospital insurance comes up, and that is: "If hospital insurance is practical and desirable, why have not the large insurance companies entered this field?" This question is answered partly in "reimbursement insurance" which a number of established insurance companies sell and which reimburses the policy-holder to the extent of his hospital bill. In some instances, the payment of the insurance is contingent on the presentation of the receipted hospital bill.

Another comment in regard to the apparent failure of established insurance companies to get into the field of hospital insurance is that these companies are extremely conservative and that this policy may keep them out, even though the risk is slight.

Despite the enthusiasm of the Texas people and of others who have been carrying on an insurance plan for varying periods, there is a number of experienced superintendents who doubt the practicability of an insurance plan and who refuse to have anything to do with one. Objections in some instances are based on the above-mentioned failure of established insurance companies to enter this field, a failure that some say indicates that the general idea is not sound. Other superintendents assert that there are other insurmountable objections, such as the obtaining of a sufficient number of policy-holders to insure the success of the scheme. Then there are some who say that the plans which apparently are successful on their showing to date really have not been fully tried,

and superintendents taking this stand want to wait longer before determining whether or not the plan is workable.

However, thus far it seems that it is up to the hospitals to prove for themselves the feasibility of hospital insurance, and Texas hospitals are leading in this movement to date.

Make Hospital Center For Industrial Service, Too

"The local hospital is without doubt the logical center for providing a satisfactory unit of service to industry."

That statement from the report of the American Hospital Association 1932 committee on workmen's compensation and liability insurance suggests a statement that ought to be incorporated in every superintendent's monthly report to his or her board of trustees. If the hospital is to become the health center of a community, as so many insist that it must, then it ought to be the health center for industry as well as for the homes and schools.

This idea, encouraged in the report, ought to get the support of a large number of hospitals and it ought to be repeated with hearty endorsement by the American Hospital Association on every occasion.

Generally speaking, hospitals in the past have been so busy providing service for the citizens as individuals that they have paid little attention to the hospital needs of industry. Many hospitals, in fact, have memories of underpaid or free service, of arguments and pleas with industrial officials before even nominal rates were paid, so they did not attempt to visualize the local industrial plants as within the scope of the hospital's activities as a community health center. Hospital contacts with industry in many instances, in the past, have been only those resulting from accident or emergency service, and the hospital superintendent gave little thought to the facilities of the institution as being used easily and most satisfactorily by industry for other purposes and on other occasions than emergencies.

Dr. J. Rollin French, Golden State Hospital, Los Angeles, who was a leader in the preparation of a manual for hospital executives on the management of insurance cases, in a foreword to the committee report in which the manual is included, says:

"Why should not all hospitals cooperate with their medical and surgical staffs and develop adequate and approved systems of service to their local industries? It would mean much to industry, to employes, and the community at large and would increase the popularity and revenue of the hospital. An approved system of medical and hospital service to industry is not complicated. The demand has in reality been created and is only awaiting the development and installation of a system of approved service to fulfill its needs."

Especially in these days when such questions as "How can we increase occupancy and utilization of hospital facilities?" are so popular, this committee report deserves special study. As intimated, it contains a manual for the guidance of hospital executives in the handling of industrial patients, the perusal of which both by hospital people and by insurance officials and employers will do much to break down misunderstanding and to build up a friendly feeling through a better appreciation of the difficulties and special conditions faced by either group.

This committee report is another outstanding contribution to the field of the American Hospital Association, which, with Chairman Howe and the members of the committee, deserve special thanks.

Will Course in Training Follow Detroit Meeting?

By OLIVER J. PECORD

Technician, Good Samaritan Hospital, Sandusky, O.

FOR several years there has been considerable agitation by hospital executives and would-be executives to have the American Hospital Association remove hospital administration from hit and miss occupations and make it, by proper education, a profession. Numerous articles have appeared in hospital magazines, also editorials, letters, outlining plans, and again at the recent convention of the American Hospital Association the matter was brought squarely before the association for consideration.

Paul Fesler, retiring president, called attention to this problem in such a manner that it would seem a shame for another convention to take place with the next president saying, "Unfortunately, nothing has been done to remedy this condition."

It may be that the subject will not even be discussed at the next convention; such things sometimes have been known to occur. But let us see what Mr. Fesler said:

It is deplorable to notice that some of the best hospitals are administered by men with no experience or training in hospital administration. It seems that it would be for the benefit of patients if a College of Hospital Administration could be created to train hospital executives.

The time has come when there should be some distinction between the tried, well trained, successful administrator, and the new, inexperienced, improperly trained and the unfit type of superintendent.

Now that the matter of training executives again has been fairly put up to the association, what will be done about it?

The subjects that came up for discussion at Detroit surely were not those to be handled by improperly trained administrators, and it is folly to suppose that any person, no matter how much he or she might know about business, can properly administer a hospital. There is no reason why we should continue to respect or employ poor guessers in the hospital field.

Two plans are proposed for training hospital administrators. The first is the preceptor plan, an instructive apprenticeship under an experienced administrator. The second plan, advocated by Mr. Fesler and others, seeks the creation of a College of Hospital Administration. The matter of practical experience to be gained in such a College is the ques-

tion which should cause the most concern. It is as impossible to make a hospital executive by handing him a book to study without actual experience as it is to make a chemist by keeping him out of the laboratory. Thus far the preceptor plan is more practical, except that it limits too severely the number of people to be trained. Both plans have their merits, but until something more definite is done than proposing plans, the hospital field will continue to be well populated with mediocre and unfit executives.

Now that the American Hospital Association again has been officially informed that the training of hospital executives is a very real problem, it is to be hoped that the association will act promptly. The prob-

lem of training is of serious importance to the association since it concerns primarily the welfare of the patient. The solution of this problem is of utmost importance to the association, since it is a reflection upon the A. H. A. to have in its ranks executives well fitted for work, but not in the hospital field.

Young men and young women who were interested enough to attend the convention in Detroit because they seek to be trained for executive work are waiting with the greatest interest for a plan which they hope will now be worked out by the American Hospital Association. Some of these people have waited for some years and have never given up hope that something would be done for them in the way of training. They are the hope of the American Hospital Association because many of them have proved their keen interest in entering the work well trained or not at all. What will the American Hospital Association do for them?

What will it do for itself?

Hospitals Asked to Join Plan of Improving Business

A SERIES of conferences for financial business and other leaders in different parts of the country recently was held to emphasize the importance of the "Industrial Rehabilitation" program, sponsored by the government as a practical means of helping to speed general business recovery. This program, in brief, urges the immediate making of repairs, improvements, etc., which are admittedly necessary, and which the institution or organization interested is in a position to finance.

It is pointed out that this simple and obvious program can be of material benefit in encouraging dealers, employes, and many other individuals and groups to do their part and to make improvements or to modernize.

It is emphasized that even small projects will aid materially, because each sale of an article, or each job that is supplied, has a very great cumulative effect in encouraging others and providing them with money to carry out similar projects in their business establishment, homes, etc.

There are a number of hospitals which are quite favorably situated from a financial standpoint at this

time, and some of these hospitals undoubtedly have been holding back and deferring improvements, purchase of new equipment, etc., although the authorities readily admit that such improvements or equipment would be most desirable in speeding service or reducing certain features of operating cost.

It is to be hoped that all hospitals in such a position and in need of modernization of departments, replacement of equipment, etc., will carry out these projects to the extent the authorities feel they are justified.

It is not the purpose of this "Industrial Rehabilitation" program, according to those active in its development, to urge huge projects that are unnecessary or even to ask any modernization or improvement that is beyond the demands or needs of the present moment. These leaders, however, feel that they cannot too greatly stress the point that if many individuals and organizations will carry out the improvements that they admit are necessary and essential, that further impetus to the recent improvement in general business will be given, and in this way the return of much more favorable business conditions will be facilitated.

THE HOSPITAL ROUND TABLE

Mimeographed Report

West Side Hospital, New York, of 27 beds, one of the smallest institutions to gain the approval of the American College of Surgeons, recently issued an annual report in mimeograph form. This report presented some interesting facts about the work of the institution and the support it must have if it is to continue to serve its area. George Rebusch is superintendent of West Side Hospital. This type of report, while less acceptable than a printed report, nevertheless is better than no report at all. Sometimes, as in the case of the West Side Hospital, good results can be obtained by mimeograph, and the hospital that has this equipment and cannot afford a printed report should by all means issue its annual statement of accomplishments, financial position, etc., to its friends in this form.

Must Pay Taxes

Says the *United States Daily*:

Employees of a state, county or city hospital are subject to Federal income tax on their salaries if the hospital is operated on the same basis as a private hospital, the Income Tax Unit, Bureau of Internal Revenue, has held (I. T. 2642).

Salaries of such employees are exempt when the hospital is conducted solely for the benefit of the indigent sick and paupers, the Unit ruled. An authorized summary of the ruling follows in full text:

Where a state or a political subdivision thereof conducts a hospital in such manner as to compete with the business of operating hospitals as carried on by private persons—that is, by taking all classes of patients regardless of their financial condition and requiring all patients able to do so to pay for the care and treatment received by them—the state or political subdivision will be regarded as performing a proprietary function.

Where, however, a state or political subdivision conducts a hospital for the benefit of the indigent sick and paupers, it will be regarded as performing an essential governmental function. The compensation received by officers and employees of a hospital conducted by a state or a political subdivision thereof in its proprietary capacity is subject to Federal income tax.

Hurting the Hospital

"The hospital got its money before we left, but it will be a long time before it gets any more money from us."

That phrase concluded a recent letter received by HOSPITAL MANAGE-

MENT from an influential business man, three members of whose family were in hospitals since the first of the year. This man was asked to comment on the service he received and responded by saying that as far as the hospital service itself was concerned, he had no complaint to make, but he did resent the lack of courtesy and the rude and brusque attitude on the part of the cashier of the hospital.

It seems that the man's wife was permitted to go home a little earlier than had been expected, and the man naturally had not arranged to make complete payment on the earlier day. When he learned that the patient was to leave at once, he went to the office to learn how he could arrange to pay the balance due on the bill, he having previously paid the weekly charges promptly.

The man asserted that the person behind the cashier's desk assumed an insulting tone and criticized him for not taking cheaper accommodations. An understanding finally was arrived at and the bill paid, as agreed, but the attitude of one person in the case offset all the fine service that the nurses and others had rendered, and if the man holds to his present determination, that hospital never again will be patronized by his family.

"It seems a pity," he wrote, "that after the institution has created a fine impression, the out-going patient should be sent away bitter because of one person."

One Collection Record

One of the most interesting topics before the field at present is the matter of collections, and in this connection it is interesting to note that one hospital superintendent recently reported that his percentage of uncollected accounts was 1.3. In other words, he averaged 98.7 per cent collections. In explaining how the total amount to be collected was arrived at, this man said that the arrange-

ments made by the hospital and the patient on the latter's admission governed all cases; in other words, if the patient made an agreement to occupy certain accommodations and to pay for them, and later was unable to meet the bill in its entirety, or any part of it, the hospital did not credit the unpaid balance to free work, but figured it as uncollected.

Laundry Is Economy

The value of a hospital operating its own laundry, even in times when commercial laundry prices have a tendency to drop, and when the volume of work for the hospital laundry is decreased, is emphasized in a little item on page 74 in this issue.

In this connection, it is interesting to note that one careful superintendent made a special study of his laundry costs recently, believing that he might be able to save money by shutting down his plant, discharging employees, and turning the work over to a commercial laundry. Several laundries have approached him with what they thought were attractive prices. However, a painstaking study of the cost of the hospital laundry, even with depleted volume, indicated that the hospital could supply all its own laundry work at the rate of 1.6 cents per pound. This was more than a cent below the best offer from a commercial laundry, not considering the fact that the hospital laundry would insure faster work and, consequently, a lower investment in linens, and that the hospital employees were under constant supervision and control in the matter of careful handling and processing of the linens.

"How's Business?"

The widespread interest which is being shown in "How's Business?" the only statistical information giving a general picture of occupancy, income, and expenses in the hospital field, was further indicated during the conference of state hospital association representatives at the American Hospital Association convention, when Homer Wickenden, director, United Hospital Fund, New York City, in a talk on a publicity program for hospitals, mentioned that "How's Business?" was the only information of its kind readily available to the field. Mr. Wickenden said he based certain estimates of reduction in income, etc., of hospitals on the figures from "How's Business?"



Indiana Hospitals Discuss Laws and Insurance Plans

A SPECIAL meeting of Indiana hospital executives, called by President George William Wolf, business manager, Home Hospital, Lafayette, brought about 30 representatives of Hoosier institutions to Lafayette October 6 for a consideration of legislative activity and hospital insurance. Among those participating in this extremely informal and practical discussion included Dr. William A. Doeppers, past president; Edward Rowlands, Methodist Hospital, president-elect; V. J. Sandt, Fairview Hospital, Laporte; Mr. and Mrs. A. G. Hahn, Deaconess Hospital, Evansville; Miss Gladys Brandt, Cass County Hospital, Logansport; Miss Eva Milburn, Putnam County Hospital, Greencastle; Nelle M. Huffman, Bartholomew County Hospital, Columbus; Miss Raechel L. Hill, state board of charities, Indianapolis; Dr. E. T. Thompson, University of Indiana Hospitals, Indianapolis; Mrs. Rinda Rains, Kings Daughters Hospital, Madison; Esther Batdorf, Home Hospital; E. C. Moeller, Lutheran Hospital, Fort Wayne; Mrs. Lillian A. Mavity, Howard County Hospital, Kokomo; Miss E. M. Charlton, Henry County Hospital, Newcastle; Sister Superior, St. Elizabeth's Hospital, Lafayette. Several hospitals were represented by staff men, including St. Mary's, Evansville, whose representative was Dr. W. S. Ehrick.

The visitors had the proposed Ohio law read to them, which plans to divert a portion of the gasoline tax to hospitals for payment for service to indigents injured in automobile accidents, on the basis of patient day cost of the previous year. The New Jersey automobile accident lien law also was read, after which there was a general discussion. In view of the fact that Indiana hospitals are protected to a considerable extent by municipal, county and township laws governing payment of service to indigents and since the proposed laws would not cover every person cared for, the visitors voted to have the legislative committee use its own judgment as to the type of law to be favored. Following a delightful lunch at the hospital, the visitors then considered the question of hospital insurance, listening to comments on different types. From this discussion it was not only evident that there was considerable interest in the subject, but that a number of hospitals contemplate the early estab-

lishment of some plan if further investigation proves its practicability.

Matthew O. Foley, editorial director, HOSPITAL MANAGEMENT, was asked to comment on legislative activities in other states and he also was invited to tell of efforts by hospitals to win greater public interest and support. In connection with the latter he urged the Indiana hospitals to work with the new A. H. A. committee on public relations in every way and expressed the hope that this committee would help make the hospital field more conscious of the need of individual action by different hospitals to educate their own communities. In connection with this he pointed to the increasing use of hospital bulletins and the widespread utilization by hospitals of material for publication in local newspapers which has been available to the field for nearly a year and which has been widely used.

Chronic Department Not Patronized

By Herman Smith, M. D.

Superintendent, Michael Reese Hospital, Chicago.

It was thought that Michael Reese Hospital's income might be increased and a new facility offered to the community by opening an unoccupied division in the private patients' building to patients suffering from chronic ailments other than tuberculosis and mental diseases.

This floor is rather ideally laid out for the purpose. It has yard level porches opening from practically every room, a fairly spacious garden court, wheel chair facilities, etc. Because of the rather complete physical therapeutic facilities of the hospital, it was thought that a number of patients suffering with chronic arthritis might utilize the service. The regular weekly rate was reduced 25 per cent and a monthly rate established approximately 30 per cent less than the regular rate. These facilities were advertised to the medical profession of Illinois, particularly Chicago, and the lay community supporting the hospital.

It is interesting to note that we have not had a single response since the unit was organized three months ago.

From round table discussion, 1932 A. H. A. convention.

Messrs. Bacon, Fesler and Wordell were good enough to give the number of patients in Presbyterian, Wesley and St. Luke's Hospitals, Chicago, who on August 10, 1932, had been in private rooms or private wards for more than three months. These four hospitals were picked as a typical cross section of urban hospital population. These figures added to those of Michael Reese Hospital show the following:

There was a total of six patients who had been in private accommodation in these hospitals more than three months and less than six months, and five patients in similar accommodations more than six months, or a total of eleven private chronic patients. The combined census of the four hospitals on this day was approximately 1100 patients. Approximately 1/10 of 1 per cent of the patients in these hospitals were private chronic patients. All except one of these eleven patients needed active nursing and hospital care, and could not have been properly cared for at home.

Investigation of one of the better known private sanatoria in Chicago where ordinarily a large number of chronic patients are treated, revealed the fact that there had been a decrease of 35-40 per cent in the number of patients treated in 1932 as compared to 1931. Many families were removing their relatives to their homes to reduce expenses. The patients remaining in the sanitarium were moving from more to less expensive accommodations. The rates in this sanitarium were moderate, being \$35 per week, which figure includes physiotherapy treatments and physicians' fees.

It is my belief that at this time general hospitals should not expend any funds upon the development of a program to attract private chronic patients.

PHILADELPHIA MEETING

The September meeting of the Philadelphia Hospital Record Librarians was held at the Stetson Hospital, with the president, Miss Casey, in the chair. Nine hospitals were represented. The following motion pictures were shown: gastroenterostomy, posterior; amputation of cervix; pylorus stenosis.

HOSPITAL BEQUESTS

For the month of September, 1932, a total of \$198,000 was bequeathed to seven hospitals in the United States by seven individuals.

In August, a total of \$71,000 was donated; in July, \$521,377, and in June, \$3,295,000.

These do not include all bequests; only those which have come to the attention of HOSPITAL MANAGEMENT.



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"If I Were Asked to Establish An Out-Patient Department"

By O. N. AUER

Director, Monmouth Memorial Hospital, Long Branch, N. J.

1. *Analyze the community to be served as to:*

- a. Present occupancy of general ward accommodations.
- b. Other facilities already present in the community for doing this job.
- c. Present use of relief agencies by residents of the community.
- d. Amount of gratis service now being performed by the medical profession in their offices and in patients' homes.
- e. Type of occupation of majority of people who would use the out-patient department.

2. *Get the feeling of:*

- a. The board of directors.
- b. The medical staff.
- c. Medical men in the community as a whole.
- d. Social agencies.
- e. Public health organizations.
- f. Public spirited citizens.

3. *Decide upon the kind of clinic the community needs and the kind you wish to establish.*

A. Medically:

- a. What clinics are needed by the community?
- b. Is adequate medical service available to man such clinics?
- c. Are there any particular types of ambulatory cases which it seems undesirable to accept?

B. Socially and financially:

- a. Shall it be free, part-pay or pay?
- b. On what basis will patient be accepted for treatment, i.e., if it is to be a free clinic, what restrictions, if any, will be set up against the acceptance of patients able to pay, and vice versa if it is to be a pay clinic?
- c. Will there be any restriction as to color, race, religion, residence in certain areas, etc.?

4. *Estimate:*

- a. The number of visits to be expected (no figures available which will fit all communities), (60-500 per year per thousand of population, depends on conditions in community).
- b. The amount of space and equip-

*a. Pharmacy. b. Physical therapy. c. X-ray. d. Dentistry.

Here is an outline of things to be considered and done by a hospital which contemplates the establishment of an out-patient department, as presented to the 1932 American Hospital Association out-patient section at Detroit. Mr. Auer spoke with reference to a department for a small hospital, but the principles he suggested, are, of course, applicable to departments of larger institutions.

ment necessary to give adequate service to this number of patients.

c. The staff, both medical and non-medical, which will be necessary.

5. *Make a budget for:*

a. Preparing the space and equipping such a department.

b. Operating expenses, including salaries and supplies. (Cost per patient visit, \$0.75 to \$1.50.)

6. *Go to the medical staff and board of directors of the hospital with a tentative plan, worked out quite carefully. Ask for their support professionally and financially.*

Some organization points:

1. Hire an experienced department head.

2. Keep in mind that the out-patient department has three functions: (a) care of sick, (b) protection of public health, (c) teaching of physicians and nurses.

3. Double up on use of space, use both morning and afternoon. Consider waiting space, privacy, etc.

4. Equipment (make a good workshop for the doctor).

5. Combine facilities of hospital and clinic.*

6. Combine records of hospital and clinic in some definite routine manner.

7. Connect hospital medical service and clinic medical service.

8. Make clinic service a stepping stone to hospital appointment on medical staff.

9. Larger clinics a few times a week better than small clinic too fre-

quently. Makes job more interesting for the doctor.

10. Have two men at least on each clinic, one to be chief.

11. Handle admission to general wards by same department or interviewer as in clinic. (a) Keep emergency service away from clinic.

12. Use same social workers for hospital wards and clinic so that service to patient is continued by same worker. Easier on patient.

13. Social service and volunteers, their value.

14. Emphasize various classifications of employes—doctors, social workers, nurses, clerical people. Don't use valuable experienced help for jobs which can be done with less valuable people.

15. Refer to books on clinic organization and suggest trips for observation to good, well established out-patient department.

AIR COOLED SURGERY

The surgery of Deaconess Hospital, Evansville, Ind., recently was equipped with an air cooling system. An emergency light for use in case of breakdown of ordinary electrical supply is another new piece of equipment of the department.

"The operation of this system of conditioning the air of hospital rooms depends largely upon precipitating the moisture, making the relative humidity much lower," says a statement. "The dry bulb temperature is not lowered a great deal. During the hot summer months the relative humidity is normally too high for comfort and in the surgery more moisture is put into the air from sterilizing instruments, as well as wet cloths, etc., all of which increases discomfort. Our machine is built to reduce the amount of moisture in the air properly and it is also equipped with a filtering device that removes all the lint and dust.

"The doctors are well pleased with the machine due to it creating such comfortable working condition on hot humid days without injuring the patient."

GROUP INSURANCE

A group life insurance policy insuring the lives of 58 employes of Allen's Invalid Home, Milledgeville, Ga., recently was issued by the Prudential Insurance Company of America. It involves a total of \$71,000. Each employe is insured for from \$1,000 to \$2,500, according to rank. The premiums will be paid in part by the employes, with the employer assuming the remainder of the expense.



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FOODS AND FOOD SERVICE

Here Are the Requirements of the Well-Balanced Meal

Dietitian Offers Practical Suggestions
to Smaller Institutions, and Gives
Hints on Good Buying Practices

By VESTA HELEN SWISHER

Dietitian, Toledo Hospital, Toledo, O.

GOOD digestion and sound health depend upon the food we eat, through mastication, the amount of water we drink, and plenty of fresh air and exercise.

There should be a balancing of the bill of fare so that the various foodstuffs which are required to nourish the body and to furnish heat and energy may be proportionately present in the food eaten. The bill of fare should provide the desired amount of protein, lipins, carbohydrates, mineral salts, water and vitamins.

There should be enough fat and carbohydrates to supply the energy needed in addition to what the protein will supply. There should be sufficient protein of the kind best suited to growth and maintenance. There should be adequate amounts of mineral salts in the proper proportions and an adequate supply of water and vitamins. Care must be taken to use one and preferably two of the foods that contain the vitamin soluble in fat. At least a pint of milk for every adult, with one of the leafy vegetables, is a safe rule. If the food factors, such as iron, calcium, and phosphorus, are provided in sufficient amounts, it is possible that enough water soluble vitamins will also be present.

The tissue-building constituent in food is called protein. Proteins contain nitrogen as the essential element in the repair and building of tissue. The white of egg and meat afford the most familiar examples of proteins. In fact, most ordinary foods contain more or less protein and are of both animal and vegetable origin. The right proportion of protein has been a subject of much controversy. According to what are regarded as the best investigations, it is generally

Here are some fundamental principles of menu making that will be of special interest and help to small hospitals without a dietitian. These principles underlie well-rounded meals, from the standpoint of the needs of the body.

10 calories of protein to every 100 calories of food.

The calorie is the measure of food value.

We are familiar with and appreciate the value of the burning of coal, which produces heat to keep us warm on cold days in winter or which will produce power to make a steam engine run. Perhaps we are familiar with the fact that food burned in the body is the source of the energy which keeps us warm and gives us power to do work. The amount of heat any given food will produce outside of the body may be measured. This makes it possible to tell how much energy each food will provide in the body and thus to judge how much food we need during the day.

Carbohydrates are heat and energy producing foods. They provide the fuel most easily and quickly available for body use. Sugars, starches and cellulose are most common examples of the carbohydrates.

Lipins are the most concentrated food nutrients that we have. Fats and oils are obtained in both animal and vegetable kingdoms. They furnish energy for heat and development. They supply force. They serve as a covering and protection

in the body. The most available sources are olive oil, bacon, butter, lard, American cheese, chocolate, oleomargarine, olives and nuts.

The daily meal should contain:

1. One pint of milk for an adult.
2. Two generous servings of any of these vegetables:
Carrots.
Turnips.
Parsnips.
Cabbage.
Onions or greens.
Beets.
String beans.
3. Potatoes every day (baked or cooked in jackets).
4. At least one serving of one of the following foods:
Meat.
Fish.
Eggs.
Cheese.
Dried peas.
Beans or lentils.
5. One of the following foods:
Raw cabbage.
Canned tomatoes.
Bananas.
Orange juice.
6. A dried or fresh fruit.
7. Bread, cereal, macaroni, or rice, and simple desserts for energy.
8. Plenty of water—8 glasses a day.

For the daily meal it is a good thing to plan in advance the groceries one will need in a week. A storekeeper cannot order his groceries from the market and expect to receive as good as he would have if he went to the market himself. He should go early enough so that the stock is not picked over or a poor quality left. Foods out of season cost more than foods in season. A cheap food may contain all the essential factors for good health, while an expensive food may not. Dry groceries may be bought in bulk and save leaks in expense.

If there were a standing weekly order for articles, such as bread, eggs and milk, this would not only help



Some views of the food service department of Toledo Hospital, of which George W. Wilson is superintendent and Miss Swisher, author of the accompanying article, is dietitian. At the left is the spacious dining room for nurses, where waitress service is offered.

At the right is a glimpse of the cafeteria where help is served. Cafeteria service, coupled with constant supervision and good management, has helped to bring the meal cost of Toledo Hospital down to slightly less than 18 cents, with salaries, according to a recent statement, and 12.45 cents for raw food.



Below is a view of the main kitchen. Note the gleaming rustless metal finishes, the large windows, and the spick and span appearance of the furnishings and equipment. For the first six months of 1932 Toledo Hospital served 140,836 meals, 91,288 of which were for personnel.

to make good use of the money, but would help to save time and keep the budget systematic.

The following are facts that should not be overlooked:

1. Buy in quantities as large as money, storage facilities and keeping qualities will permit.

2. Cereals are cheaper when purchased in bulk. So are all staples, but they should be purchased at a clean wholesale house where the bins are mice-proof.

3. The more one has to economize the more necessity it is to use the required amount of milk for the children. Each child should be allowed a quart of milk a day. A pint of milk for every adult should be allowed.

4. The cheaper cuts of meat not only cost less, but have as much food value per pound.

5. Make an inventory of the food on hand before going to market.

6. Prunes numbering 50-60 to the pound are most economical.

7. Dried fruits are more economical than fresh fruits for the adults.

8. Molasses is unlike sugar in that it is rich in iron and calcium and is a good laxative.

9. It is poor economy to buy butter by the pound. Every hospital has ice refrigeration now-a-days and can keep a case of butter nicely.

10. When marketing, specify the amount wanted of any article and be sure to get the full amount paid for. Watch the scales.

11. Use all left-overs and use the water in which vegetables are boiled in making soups and sauces.

A weekly record, consisting of headings and ruled lines under each heading, showing the amount of foodstuffs and the cost, will prove a time-saver for many people in charge of hospital food service. This record may have the following headings, with space beneath to show quantities and costs of each item:

Bread, cereal, cake, flour, rice, macaroni.

Milk, cream, cheese.

Meat, fish.

Vegetables, fruits.

Butter, eggs.

Sugar, tea, coffee, miscellaneous.

I consider the following a well balanced menu for the month of October:

BREAKFAST

Orange Juice
Cooked Cereal with Cream
Frizzled Ham with Omelet
Date Bran Muffins
Coffee

LUNCHEON

Chicken in Patties
Rice Gems Fruit Salad
Homestead Pudding
Orange Sauce Coffee

DINNER

Fruit Cup with Lime
Baked Fish with Bread Stuffing
Baked Stuffed Potato
Buttered Spinach Tomato Aspic
Lemon Sherbert Cakes
Coffee

Essentials of Refrigeration for Food Stuffs

By J. PAUL BOLLO

WITH many foods, three factors leading to their growth are the same factors which, if uncontrolled, destroy our food supply. These factors are heat, moisture and time.

Heat is the most important. Heat is necessary for growth and as soon as growth is finished the same heat brings about decay. Decay is caused by uncontrolled growth of bacteria. To retard bacterial growth in most foods, a temperature of 40 degrees Fahrenheit or less is needed.

Refrigeration is therefore an important topic. There are two general classifications of refrigeration—the use of ice, and mechanical refrigeration.

Every type and class of food has its own refrigerating problem, but, except in the most unusual cases, mechanical systems have many advantages over the old method of ice cooling.

Various types of mechanical refrigeration can be used. The particular requirements for food storage should be studied and the proper system adopted.

The three desired essentials of all types of refrigeration are the same. Refrigeration must give the proper temperature, correct humidity and ample air circulation in order to obtain the ideal conditions for food storage. Because of the various temperatures needed for the different types of foods, the average department has several food storage boxes.

The usual equipment of refrigerators in the medium size hotel or club are grouped as storage boxes and service boxes.

Adjacent to the storeroom there is usually located large refrigerators for the storage of the following supplies. The temperatures in degrees, Fahrenheit, most satisfactory for these boxes, are generally as follows:

Fresh meats	34
Frozen foods	15
Smoked meats	36
Oysters	34
Milk, butter and eggs.....	36
Cheese	38
Fruits and vegetables.....	40

These refrigerators are usually grouped and controlled by one or

From "The Analyst," R. M. Grinstead & Co., New York

two vestibules. There should also be a refrigerator for garbage, as well as for ice storage, the latter adjacent to the ice making tank.

The following service boxes and their temperature are usually found on the kitchen floor:

Cook's vegetable refrigerator....	36
Cut meat refrigerator.....	34
Consomme refrigerator	20
Butcher's refrigerator	34
Fish refrigerator	32
Ice cream refrigerator.....	0
Serving pantry refrigerator.....	38
Helps' pantry refrigerator.....	38
Pastry refrigerator	36
Milk and cream refrigerator....	34
Oyster refrigerator	38
Baker's refrigerator	36

The second essential of proper refrigeration is humidity. Correct humidity in refrigeration is protection against heavy shrinkage and spoilage loss.

A test using beef sirloin stored at 40 degrees constant temperature, but on varying humidity, showed the following dehydration loss. At 60 per cent relative humidity, which is comparatively dry, the meat showed a 4.25 per cent weight loss at the end of 24 hours and was discolored, requiring heavy trimming. At the end of 48 hours the weight loss was 7.6 per cent and further discoloration was shown. At the end of 72 hours the total weight loss was 9.8 per cent and the meat was not salable. The 60 per cent relative humidity is too dry for proper meat storage.

A test, at the other extreme of too much moisture in the air, was made on the same type of meat at the same temperature and at 100 per cent relative humidity. There was no weight loss in this meat at the end of 72 hours. Due to excessive dampness, however, the meat was slimy, had a strong odor and was unsalable.

For general purposes the ideal relative humidity for meat storage is 85 per cent. At the end of 24 hours a piece of sirloin stored in the refrigerator at 40 degrees and 85 per cent relative humidity showed a loss of 2 per cent in weight. In 48 hours a loss in weight of 3.75 per cent and at 72 hours a loss of 5.4 per cent was shown. The quality at the end of this period was good.

Some foods require faster air circulation while stored in refrigerators



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than others. Generally speaking, meats, poultry, dairy products and most fruits require medium circulation, while vegetables need a faster circulation of air.

Some foods are susceptible to odors, readily absorbing the distinct odors from other foods, causing spoilage. Eggs and butter are the two most susceptible foods, while melons, fish and onions are the greatest offenders. Care must be taken in

food storage to keep foods with strong odors apart from those absorbing these odors. Devices are now on the market which, if used in the small household type of refrigerator, absorb ice box odors. This permits the storage of all type foods in the same refrigerator.

The efficiency of refrigerator equipment tends largely to the care which it is given while being used. Proper supervision is necessary to

maintain the desired temperatures. Coils must be defrosted periodically as directed by those manufacturing the equipment, and above all, cleanliness is most important.

Ample and proper refrigerated space, well maintained, is of vital importance to the food industry. Too much stress cannot be made on the necessity of good refrigeration and its maintenance to prevent food spoilage.

How University of Michigan Hospital Figures Cost Per Meal

Understanding of Operation Which Is Being Accounted for Necessary for Successful Cost Record, Says Writer, Who Details System in Ann Arbor Institution

By GEORGE BUGBEE

Office Manager, University Hospital, Ann Arbor, Mich.

THOSE of us who are daily endeavoring to interpret the vital activities of hospitals in figures often are unpleasantly surprised by the negative interest shown in the results of our enthusiastic efforts.

Such a reception of financial reports should be a signal for careful consideration. Clerical accuracy is necessarily of first importance. However, such accuracy may relatively easily be verified. It is often possible that the fault lies in inadequate understanding of the operations which the financial records are in theory to clarify.

Successful cost records can only be prepared by an accountant who is familiar with the operation for which he is trying to account. This understanding must be so complete as not only to allow for the correct grouping of expenses, but must also bring the realization that cost records are not the final answer to all managerial problems. They rather are only an important pattern to be qualified by those factors which cannot be interpreted in that one language of accountants, namely, figures. Nevertheless, to the management honest figures—which implies intelligent preparation—must remain the point of departure for executive judgment.

As has been stated, it is important for the accountant to realize that financial reports do not show the whole picture. In the same way it is important for those who have been harassed by such reports to remem-

ber that either above or below that figure which may, weighed in the light of other factors, represent ideal efficiency is that crassly practical amount available to be spent. Unfortunate as it may seem, in our very materialistic world, we find that hospitals which are not expected to evidence this tendency in performing their appointed function, are none the less as closely bound as any by funds available.

Practically all hospitals have some cost records for the dietetics department. The problem of planning correct diets in the treatment of certain diseases and of feeding a well balanced diet to a large number of patients made critical by illness are of primary importance in the dietetics department. However, such aims must be accomplished at a reasonable cost. Often those dietetic cost records available are prepared by the dietitian, an evidence of the realization that cost is and must be one standard by which her efforts will be judged. Since this is true, it is of vital interest to the dietitian that the cost measurements of her work be prepared in the best possible fashion. While it has been stated that the accountant must be familiar with the operations which he is endeavoring to portray in figures, it is equally important that the dietitian be sufficiently familiar with accounting to judge whether such portrayal is correct. Not only must she have accurate costs for her own guidance, but of

equal importance to her is the assurance that the management shall have accurate and true figures for judging the financial success of her activities.

Certain rules are fundamental in preparing all cost records. Expenses must be so accumulated as to yield a figure which represents only the costs for the time interval for which the report is being prepared.

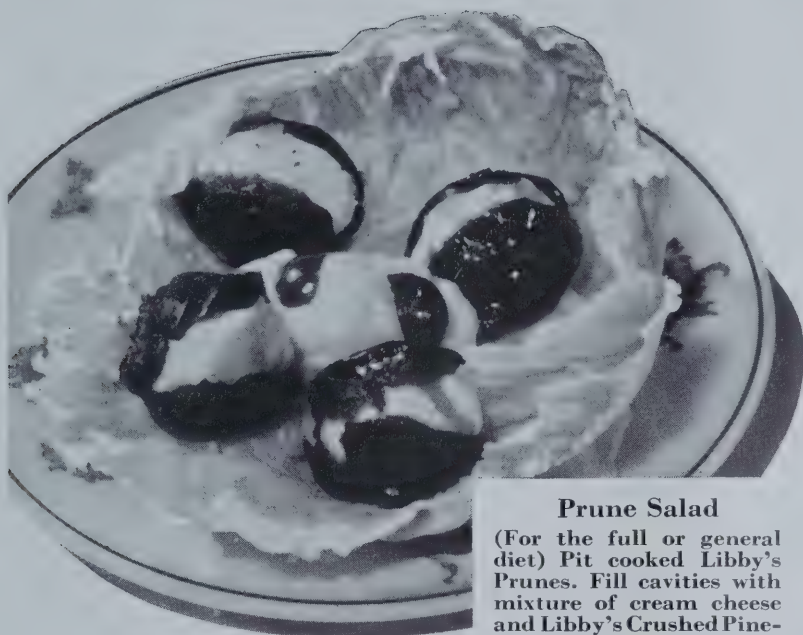
Secondly, the total of expenses must be weighed on the basis of the units of service rendered during the period.

To accomplish the first of the above mentioned points various methods have been developed. One month is often the time interval for which reports are prepared. It is important that only the salaries of employees who have worked in the dietetics department during that month shall be charged to the department. Payrolls are sometimes maintained on a monthly basis which makes this operation very simple. However, if employees are paid on an hourly or weekly basis, it is important that regardless of pay intervals the department be charged only for the labor expense for the exact number of days covered by the report.

In the same way raw food and supplies should be charged only in the amount used during the interval. Seasonal commodities are often purchased in quantities. The monthly accumulation for cost work should not include the amount purchased during the period but rather the

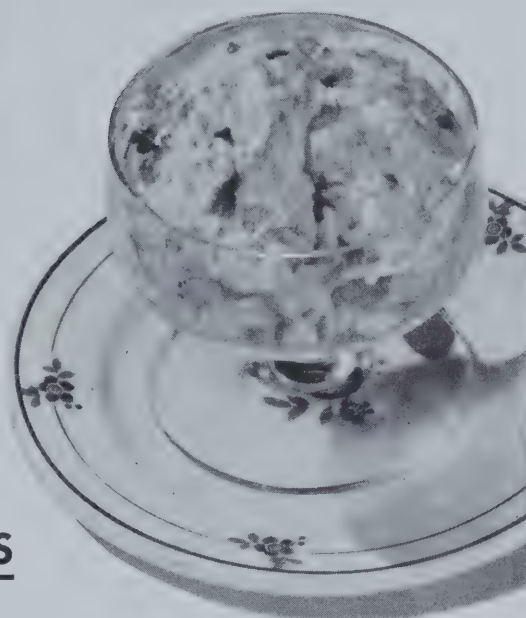
SEE WHAT THESE WILL DO FOR EVEN THE

fussiest
appetites



Prune Salad

(For the full or general diet) Pit cooked Libby's Prunes. Fill cavities with mixture of cream cheese and Libby's Crushed Pineapple. Serve on lettuce, garnished with mayonnaise and rubettes.



ENTICING, LOW-COST DISHES MADE WITH LIBBY'S PRUNES

● It's not so difficult, after all, to make prunes—those familiar prunes—interesting to even the fussiest hospital appetites.

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the prune dishes shown on this page. New, attractive, with all that delicate, enticing flavor of Libby's Prunes.

Grown in the famous Santa Clara Valley of California, Libby's Prunes are the finest obtainable. Meaty, firm, excellent in quality. Dehydrated, sterilized and packed scientifically by experts, in Libby's own plants near the growing orchards.

So, dietetically speaking, Libby's Prunes have all the nutritive properties for which prunes are valued by hospitals. For the uses suggested here, for convalescent and anti-constipation diets, as well as the many other uses you know so well.

And, economically speaking, you can serve Libby's Prunes often, in as large quantity as you need. Costing little, they give you true Libby value—a superior, uniform quality and full-measure pack that you can count on.

Order Libby's Dried Prunes, in cans or in bulk, from your usual source of supply. Remember, too, that Libby packs many other fine food products expressly for hospital use.

Libby, McNeill & Libby

Dept HM-29, Welfare Bldg., Chicago

Prune Ice Cream

(For high caloric or soft diet) Soak Libby's Prunes overnight. Simmer gently, ½ hour. Put through a coarse sieve, and add to ice cream mixture. Freeze and serve.



These Libby Foods of finest flavor are now packed in regular and special sizes for institutions:

Red Raspberries
Tomato Purée
Corn, Beets
Hawaiian Pineapple
California Fruits
Spinach, Kraut
Jams, Jellies
Pork and Beans
Tomato Juice
Olives, Pickles
Mustard
Bouillon Cubes
Beef Extract
Peas, Catchup
Chili Sauce, Salmon
Evaporated Milk
Mince Meat
Boneless Chicken
Stringless Beans
Santa Clara Prunes
in Syrup
Strawberries
Loganberries
California Asparagus



Norwegian Pudding

(For children's trays) Simmer soaked Libby's Prunes, ½ hr. Cool. Pit. Cook juice with stick of cinnamon, sugar, lemon juice, a few minutes. Thicken with cornstarch. Pour over prunes. Serve cold.



THIS

Cheerful "Adobe" Coloring...

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earnest pleadings fail
serve the diet on

**adobe
ware**

*... and Watch
the Patient Eat*

THIS new Adobe ware with its revolutionary new coloring might very easily have been the inspiration of some discouraged patient, weary of turning from all diets with disgust. For its warm and unusual coloring builds up the optic appeal of the most depressing foods—actually makes the most monotonous diets gaily appetizing.

The fact that there is a direct connection between the appearance of a meal and the amount that is eaten is not news to you. But when you compare your present china, as many hospitals are doing, with this new Adobe ware you may realize for the first time just how important the china itself really is. China is the frame, the "package." Crude in shape, lifeless in pattern, it naturally blunts the appetite, no matter how carefully your food is prepared and arranged. Warm, inviting, it stimulates and, in the case of Adobe, brings out the full brilliance of Nature's own colors in foods.

We urge you to forget for a moment the cares



See what happens when it's rubbed out!

of your office, the pressure of reduced budgets—and to examine this ware at the first opportunity. Compare it with your china by placing a simple diet on its mellowing, soothing surface. Call in physicians, dietitians. Get their opinion. Then and only then can you decide if you can afford to pass by this opportunity to earn the everlasting appreciation of every patient under your care.

Sample stocks of Adobe ware are now in the hands of leading supply dealers in all principal cities. See this assortment of samples. If you have any difficulty in locating a representative number, please write us at Syracuse and we shall see that samples are furnished you. Then if you have any special pattern in mind, you can call on our art staff to supply some suggested specimens in colors. There is no cost for this service. And you may be better satisfied in the end with a pattern exclusively yours.

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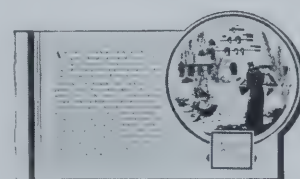


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COOKING FUEL COSTS

CUT \$400⁰⁰ • A MONTH BY
HOTEL SHERMAN, CHICAGO

A
“Facts and Figures”
story . . . for every
manager who wants
to cut cooking costs

EARLY in 1930 the Hotel Sherman Company, Chicago, decided to save money by replacing obsolete cooking equipment. New Vulcan, All-Hot-Top and Open Top Insulated, Heat Controlled Gas Ranges, Vulcan Deep Fat Fryers, Radiant and Salamander Broilers were installed.

Mr. Albert H. Byfield, Vice-President, wrote recently: “The last seven months of 1930 cost us \$7,003.00 in gas. The corresponding seven months of 1931, during which time we used the new ranges, showed a corresponding cost of only \$4,017.00. January, 1932, shows a saving of approximately \$400.00 as compared to the average of the preceding four years,

and February is nearly as good.”

The new equipment paid for itself in eight months out of the \$400.00 a month savings in fuel . . . and now the \$400.00 monthly saving is clear gain.

Everyone may not be able to show as large a saving, because the operating cost is based on amount of equipment, cooking done, age of equipment and fuel. But, we do say that it will be to the advantage of managers of hotels, restaurants, clubs, hospitals and schools to look over their cooking equipment, figure the cost of operation and find out the Vulcan story.



5 WAYS THE NEW VULCAN GAS EQUIPMENT CUTS COOKING COSTS

1 Heat losses and gas consumption in oven cooking reduced by heavily insulated oven walls.

2 Over-heated ovens and resultant food shrinkage and waste of gas prevented by oven heat control.

3 Oven heat used more effectively in baking and roasting by improved flue system.

4 Top cooking made more efficient by All-Hot-Top. Heat of one burner spreads under entire top. All rings of burner quickly heat the top. Then one ring keeps it hot economically.

5 Labor costs reduced because range requires less watching due to automatic control . . . smooth front of range is kept clean with less work. More comfortable working conditions increase the efficiency of help.

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VULCAN EQUIPMENT MAKES GAS THE MODERN EFFICIENCY FUEL . . . CLEAN, FAST AND ECONOMICAL

DIETETICS DEPARTMENT—COST PER MEAL

1929-30 1930-31 1931

	Avg.	Avg.	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	April	May	June	Total
1 All units—															
Food	\$.169	\$.144	\$.124	\$.120	\$.121	\$.126	\$.130	\$.125	\$.113	\$.107	\$.112	\$.114	\$.111	\$.108	\$.119
Labor .....	.073	.076	.083	.080	.081	.077	.084	.088	.081	.079	.079	.079	.082	.081	.081
Supplies .....	.011	.011	.014	.020	.020	.015	.014	.017	.012	.012	.011	.016	.014	.015	.014
Total .....	.253	.232	.222	.220	.222	.217	.228	.230	.206	.198	.202	.209	.207	.203	.214
2 Main kitchen—															
Food	\$.118	\$.112	\$.099	\$.101	\$.094	\$.096	\$.103	\$.099	\$.094	\$.090	\$.099	\$.099	\$.095	\$.090	\$.097
Labor .....	.019	.023	.024	.024	.022	.020	.023	.026	.023	.025	.025	.024	.025	.026	.024
Supplies .....	.004	.005	.005	.004	.005	.005	.004	.006	.004	.005	.004	.006	.004	.004	.005
Total .....	.141	.139	.129	.128	.122	.121	.131	.130	.121	.119	.127	.129	.124	.120	.125
3 Ward service, main kitchen*—															
Food	\$.033	\$.029	\$.022	\$.024	\$.025	\$.027	\$.027	\$.025	\$.022	\$.021	\$.020	\$.020	\$.019	\$.019	\$.023
Labor .....	.053	.052	.051	.051	.052	.050	.051	.051	.050	.051	.050	.051	.051	.050	.051
Supplies .....	.007	.007	.008	.007	.007	.007	.006	.008	.006	.006	.004	.015	.005	.007	.007
Total .....	.093	.089	.081	.081	.083	.084	.085	.084	.078	.078	.074	.086	.075	.076	.080
4 Dining room service, main kitchen**—															
Food	\$.027	\$.023	\$.020	\$.021	\$.021	\$.023	\$.026	\$.027	\$.023	\$.021	\$.021	\$.021	\$.020	\$.019	\$.022
Labor .....	.040	.040	.049	.048	.044	.040	.050	.056	.052	.049	.047	.052	.052	.055	.049
Supplies .....	.005	.006	.007	.007	.006	.006	.007	.008	.007	.006	.004	.005	.005	.007	.006
Total .....	.071	.068	.076	.077	.072	.068	.084	.091	.081	.076	.073	.078	.077	.081	.077
5 Private, 6—															
Food	\$.276	\$.236	\$.192	\$.181	\$.226	\$.251	\$.224	\$.190	\$.171	\$.152	\$.184	\$.163	\$.182	\$.200	\$.189
Labor .....	.109	.126	.132	.112	.186	.171	.167	.147	.134	.084	.100	.094	.129	.166	.129
Supplies .....	.022	.017	.020	.013	.026	.025	.037	.025	.021	.015	.012	.012	.018	.028	.019
Total .....	.407	.378	.343	.305	.438	.446	.428	.361	.326	.251	.297	.269	.328	.394	.337
6 Metabolism, 2—															
Food	\$.253	\$.216	\$.210	\$.223	\$.216	\$.169	\$.196	\$.175	\$.163	\$.152	\$.158	\$.152	\$.139	\$.151	\$.174
Labor .....	.139	.150	.150	.160	.146	.116	.135	.138	.118	.110	.125	.119	.123	.137	.130
Supplies .....	.023	.023	.030	.040	.023	.021	.017	.028	.017	.040	.023	.027	.013	.025	.025
Total .....	.415	.390	.389	.423	.385	.306	.347	.341	.297	.301	.306	.308	.275	.313	.329
7 Metabolism, 6—															
Food	\$.101	\$.098	\$.080	\$.068	\$.058	\$.079	\$.085	\$.074	\$.065	\$.058	\$.050	\$.042	\$.040	\$.037	\$.059
Labor .....	.074	.049	.076	.057	.054	.056	.059	.060	.039	.035	.035	.034	.034	.038	.045
Supplies .....	.020	.010	.011	.013	.016	.011	.009	.013	.007	.007	.006	.006	.005	.008	.009
Total .....	.194	.158	.167	.138	.129	.145	.153	.147	.111	.100	.091	.081	.079	.083	.113
8 Commercial cafeteria—															
Food	\$.173	\$.162	\$.129	\$.129	\$.151	\$.131	\$.131	\$.133	\$.116	\$.102	\$.104	\$.101	\$.095	\$.104	\$.119
Labor .....	.068	.080	.095	.088	.102	.094	.095	.100	.090	.088	.083	.085	.092	.095	.092
Supplies .....	.006	.006	.011	.012	.012	.014	.014	.014	.011	.012	.009	.011	.011	.014	.012
Total .....	.247	.249	.235	.229	.265	.238	.240	.247	.218	.201	.196	.197	.198	.214	.223
9 Convalescent—															
Food	\$.169	\$.155	\$.127	\$.122	\$.128	\$.128	\$.131	\$.122	\$.108	\$.101	\$.097	\$.100	\$.098	\$.092	\$.113
Labor .....	.091	.090	.089	.083	.086	.093	.097	.107	.089	.088	.091	.086	.090	.082	.090
Supplies .....	.012	.005	.008	.008	.008	.009	.009	.011	.007	.016	.005	.006	.006	.007	.008
Total .....	.271	.251	.223	.212	.222	.230	.237	.240	.204	.205	.194	.191	.194	.181	.210
10 Milk laboratory—															
Food	\$.140	\$.123	\$.107	\$.092	\$.096	\$.124	\$.135	\$.116	\$.110	\$.102	\$.089	\$.095	\$.100	\$.119	\$.106
Labor .....	.105	.122	.105	.094	.095	.142	.149	.162	.154	.139	.099	.097	.089	.132	.119
Supplies .....	.028	.032	.031	.023	.080	.124	.068	.085	.049	.052	.042	.045	.042	.052	.050
Total .....	.273	.277	.243	.214	.271	.304	.353	.362	.314	.292	.231	.237	.231	.303	.275
South department—															
Food	\$.225	\$.134	\$.114	\$.127	\$.142	\$.124	\$.108	\$.107	\$.083	\$.081	\$.075	\$.114	\$.097	\$.123	\$.108
Labor .....	.081	.067	.070	.072	.077	.072	.074	.080	.077	.075	.076	.073	.071	.076	.074
Supplies .....	.013	.000	.011	.018	.014	.008	.013	.010	.007	.007	.005	.006	.008	.009	.010
Total .....	.318	.212	.195	.217	.233	.206	.196	.197	.166	.163	.156	.193	.175	.208	.192

*To secure cost of a meal served on ward, add 2 and 3. **To secure cost of a meal served in employees' dining room, add 2 and 4.

Figure 1

amount actually consumed. In large organizations the storeroom acts as a reservoir to which all purchases are charged. For the storeroom, charges are made to the dietetics and other departments on the basis of daily or weekly requisitions for commodities issued. The operation of the storeroom, while requiring a certain amount of clerical effort, is not only the best method of accumulating costs but, in addition, is a very satisfactory method for controlling the use of all commodities.

The total of expenses for the dietetics department for each month is a figure of some value for comparison from month to month. However, variations in the monthly total must be measured against some index

showing the variations in service rendered. An increase in expense alone may mean either a reduction in efficiency or an increase in meals served. We must, therefore, reduce our monthly total to a unit cost which will weigh total cost on the basis of service.

It is the accountant's responsibility to produce the total monthly expenses, but it is the responsibility of the dietitian to account for the units of service, namely, meals served by her department during the same period of time. Often the accuracy of unit meal costs are as much affected by lack of correct figures for meals served as by an incorrect accumulation of the total cost. One almost standard practice in preparing unit

raw food costs is proof of this contention. The unit of service for the dietetics department is not a meal day, but rather an individual meal. Because of lack of understanding of the value of accuracy it has been the practice to divide total raw food costs by patient days, assuming that each patient day represents three meals. The total patient days of service is known in all hospitals. However, the result is the raw food cost per patient day, not the raw food cost for serving three meals. This may seem to be a fine point. Nevertheless, experience in this institution has shown that the variation between actual meals served and an estimate based on census will vary as much as 20 per cent. Therefore, in order

CONVALESCENT HOSPITAL, DIETETICS—JANUARY THROUGH JUNE, 1932

	January	February	March	April	May	June
1123 Heads of sub-departments.....	\$ 203.66	\$ 203.66	\$ 203.66	\$ 203.66	\$ 166.32	\$ 96.60
1180 Kitchen help and dishwashers.....	603.83	596.61	659.63	626.39	667.01	619.23
1182 Waiters, waitresses, etc.....	493.53	518.15	501.00	509.86	516.64	518.03
1184 Cooks	253.33	253.33	253.33	253.33	253.33	253.37
Total personal services.....	\$1,554.35	\$1,571.75	\$1,617.62	\$1,593.24	\$1,603.30	\$1,487.23
1220 Stationery and office supplies.....	\$ 3.08	\$ 2.75	\$ 1.94	\$ 3.98	\$ 2.97	\$ 3.77
1280 Materials and general supplies.....	18.98	37.90	17.92	23.77	20.62	42.16
1281A Groceries and baked goods.....	462.61	457.46	455.86	481.12	412.56	409.92
1281B Milk, cream and cottage cheese.....	429.06	417.49	369.62	377.95	400.68	383.68
1281C Butter and eggs.....	215.66	211.40	187.97	170.22	164.33	153.74
1281D Fresh vegetables and fruit.....	228.56	219.60	237.53	309.00	326.77	277.36
1281E Meat, poultry and fish.....	487.72	416.00	372.49	430.70	363.60	345.85
1281K Ice cream	27.01	32.84	22.90	26.99	23.68	33.71
1281 Prepared food	46.76	44.50	76.21	65.11	51.71	78.02
1285 Cleaning supplies	4.51	2.98	4.93	5.59	8.44	5.42
1287 Laundry	22.26	19.97	17.39	18.89	26.03	24.68
1295 Depreciation of equipment.....	73.49	73.66	52.10	51.86	48.42	47.91
Total commodities	\$2,019.70	\$1,936.55	\$1,816.86	\$1,965.18	\$1,849.81	\$1,806.22
Departmental total	\$3,574.05	\$3,508.30	\$3,434.48	\$3,558.42	\$3,453.11	\$3,293.45
Meal census	17,551	17,806	17,691	18,623	17,749	18,245
Total cost per meal.....	\$.2036	\$.2053	\$.1941	\$.1911	\$.1945	\$.1805
Salary cost per meal.....	.0885	.0882	.0914	.0855	.0903	.0815
Food cost per meal.....	.1081	.1010	.0973	.0999	.0982	.0922
Miscellaneous cost per meal.....	.0070	.0161	.0054	.0055	.0060	.0068

Figure II

to secure accuracy the dietitian should keep very careful account of meals served rather than depending upon estimates for reporting the work of her department.

Accurate unit meal costs are the ultimate aim of dietetics cost records. However, variations in that unit cost are only the signal for further analysis. A satisfactory breakdown of this figure may be accomplished by dividing the total cost into the cost for raw food, for labor, and for supplies with a unit cost for each of these divisions. This division separates the expenses into those which are more or less fixed and those which may vary with the demand for service. Thus for normal variations in demand the total labor cost is very nearly a constant. As a result, unit labor cost variations are not significant within certain limits. We expect that during relatively slack periods that labor costs per meal will be high, the converse being true during periods of heavy demand.

While the unit labor cost has only a qualified significance, its separation from food and supplies serves to increase the value of the unit cost interpretation of these two expenses. Assuming no fluctuations in commodity markets, it may be said that the unit raw food cost should remain a constant. Totals of food purchased for a period may vary, but total food cost per meal should be substantially the same. Increases in unit raw food costs require an explanation. A variation may mean either a change in food prices, a change in the general quality of food served, inefficient menu planning, or a misuse of the

raw food issued.

The unit cost of supplies is susceptible to much the same consideration as the unit raw food cost.

All unit costs increase in value as figures are available for comparison over long periods of time. It is in such comparisons that a unit labor cost is principally of value. Unit food and supply costs are of distinct value for comparative purposes monthly as well as over long periods.

Unit costs for the entire department represent the minimum in cost figure which should be available for the dietitian.

The large hospital with a complex organization, with several kitchens and many serving units, warrants a more detailed cost analysis than is obtained by dividing total costs by total meals served. This can be obtained by following the same principles as outlined above. Each division of the department is treated as a unit in the same way that the dietetics department is separated from other departments of the hospital. While clerical procedure is more complex, principles remain the same.

Figure I illustrates the type of cost reports prepared in this institution for the dietetics department. The first group of figures show total costs for the entire department. The main kitchen figures represent the cost of prepared food in food carts. Ward service is the additional cost for serving; main kitchen food in serving kitchens on the various ward units. Employee service is the cost of serving main kitchen food in the various employee dining rooms and cafeterias. The balance of the cost divisions rep-

resent the total costs for preparing and serving food in individual units such as the private pavilions and units having a separate identity.

Unit cost figures as illustrated in Figure I are not, as has been stated before, to be used without discretion. The significance of such figures must be considered in the light of many other factors. However, such unit costs in a very simple form call to the attention of the management the financial trends. Variations may be readily explainable and, on the other hand, may require further analysis. Such analysis can always be made by an examination of the detail figures from which unit costs are prepared.

Figure II is an example of the report from which unit costs are prepared. Examination of these totals will often indicate the particular item needing investigation. Such analysis may, however, go back as far as the time cards of the individual employees or the storeroom requisition for commodities which when accumulated represent the totals shown (Fig. II).

These financial reports do not answer the problem of management of the dietetics department. The dietitian so provided with cost records may indeed find that greater attention to menu planning, portions served, and distribution of personnel are necessary. Such cost records are, however, honest. The exact financial picture is shown. Administrative decision is based on the true financial background. While lack of attention to the cost of service will be evident, economy of operation will be equally evident, an important incentive to the conscientious.

VAN EQUIPMENT

78 YEARS LEADERSHIP
in the Preparation and Serving of Food in
America's Foremost Institutions

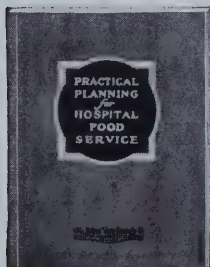
Right
Main Kitchen,
Christ Hospital,
Van Equipment
throughout.

Below
Van Floor Food
Service Trucks,
Christ Hospital.



Some Notable Installations Now in Progress or Recently Completed

ALLEN MEMORIAL HOME.....Mobile, Ala.
CHRIST HOSPITAL.....Cincinnati, O.
FLINT GOODRIDGE HOSPITAL.....New Orleans, La.
GOUVENOR HOSPITAL.....New York.
GREEN POINT HOSPITAL.....New York.
LICKING COUNTY TUBERCULOSIS HOSP.....Newark, O.
LINCOLN HOSPITAL.....New York.
MALDEN HOSPITAL.....Malden, Mass.
MASSACHUSETTS STATE PRISON HOSP.....Norfolk, Mass.
U. S. MARINE HOSPITAL.....New Orleans, La.
U. S. VETERANS HOSPITAL.....Gulf Port, Miss.
SEA VIEW HOSPITAL.....New York.
SPRINGFIELD GENERAL HOSPITAL.....Springfield, Mass.
WARE COUNTY HOSPITAL.....Waycross, Ga.
QUEENS HOSPITAL.....New York.



Write for this Book

Not a catalog. Full of information for hospital executives. Plans, photographs references. Valuable hand book for those contemplating new kitchen equipment or modernizing old. Free on request.

For three-quarters of a century The John Van Company has pioneered in the design, engineering, production and installation of food equipment.

Decade by decade the most representative hospitals that have been erected have been Van-equipped. Right now Van Equipment is being installed in the most important new institutions and it is replacing obsolete equipment in the old.

No order is too large for our capacity. None too small for our conscientious attention. We solicit correspondence. Address Department HO.

The John Van Range Co.
EQUIPMENT FOR THE PREPARATION AND SERVING OF FOOD
Cincinnati

ATLANTA
MUSKOGEE

BOSTON
NEW ORLEANS

CLEVELAND

DETROIT
NEW YORK

a McNICOL PATTERN for Every Purpose

A lightweight china built to stand hard knocks, McNicol "Embassy" shape china is ideal for better hospitals, hotels, clubs or restaurants.

Just one of the many distinctive McNicol patterns available in band and line and print designs.

This attractive decalcomania pattern represents just one of the attractive, colorful designs McNicol offers.



DOZENS of McNicol patterns from which to choose—band and line, prints, decalcomanias—a style for every requirement. Or, if you wish, we'll design a pattern for your exclusive use, as we have for hundreds of the finest hospitals, clubs, restaurants, cafeterias and hotels.

Made by the tunnel kiln process, McNicol China renders years of service; its extra-hard glaze stands up under the hardest wear; its uniform texture and even, sparkling-white color make the food you serve more tempting.

Your dealer will gladly tell you about McNicol China. Ask him!

The
D.E. McNICOL POTTERY Co.
of West Virginia
CLARKSBURG, W. VA.

WIDE VARIETY OF FROZEN FOODS

Although comparatively new, the frozen food industry is fast establishing itself. So many different food products are now being sold to the consumers in a frozen condition, and experimental research has proved the possibility of freezing successfully so many others, that the importance of freezing as a method of food preservation must be recognized.

A recent survey of the situation made by the Frozen Foods Association of America shows that at present there are between 60 and 70 separate and distinct food products which are being frozen and sold commercially. This total simply lists the various cuts of meats under the two or three headings of beef, lamb, pork, etc., and if each different cut were counted as a separate item the list would be well over the 100 mark.

In addition there are approximately 100 more products which have been the subject of investigation and experiment, both by agricultural experiment stations and commercial organizations interested in the possibilities of freezing. Although not every product so investigated has proved suitable for freezing, the greater majority of them have survived the test and can be frozen successfully in commercially profitable quantities as the public demands them.

This record made in the space of a few years compares favorably with the older methods of food preservation. For example, the canning industry reported recently that there were approximately 244 varieties of canned foods divided as follows: 65 varieties of vegetables, 43 of fruits, 37 of fish and shellfish, 29 of meats, 30 of soups, 28 of specialties, and 12 of ready-made entrees. Most of the items on this list, with the possible exception of the soups, can also be included on the list of products which have been frozen successfully. On the other hand, the roster of frozen items would contain a number of meat products which are not canned successfully, as well as various fruits, especially tropical fruits, which thus far have not been commercially successful as canned products.

Inasmuch as the canning industry goes back more than 100 years to the days when Napoleon Bonaparte awarded a prize of 12,000 francs to Nicholas Appert for his canning inventions, and the freezing industry is of comparatively recent origin, the future possibilities of freezing are most promising.

In the commercial freezing of foods the Frosted Foods Sales Corporation, a subsidiary of General Foods, leads the list at present with approximately 40 items, again not counting the various cuts of meat as separate items, but listing beef as one item, lamb as another, pork as a third, etc. These Birdseye Frosted Foods, named after Clarence Birdseye, inventor of the freezing process used, are being sold at present in about 300 stores in the New England states and in New York, New Jersey, Pennsylvania and Maryland. It is expected by the end of the year about 800 stores will handle them. The sale of these products has also begun on the Pacific Coast.

The berry packers of the Northwest annually freeze 50,000,000 pounds of berries, principally strawberries, blackberries and raspberries. The great part of these are frozen in barrels and sold to the pie-baking and similar trades, but in the last few years approximately 1,600,000 pounds have been frozen in one-pound containers and sold through retail stores.

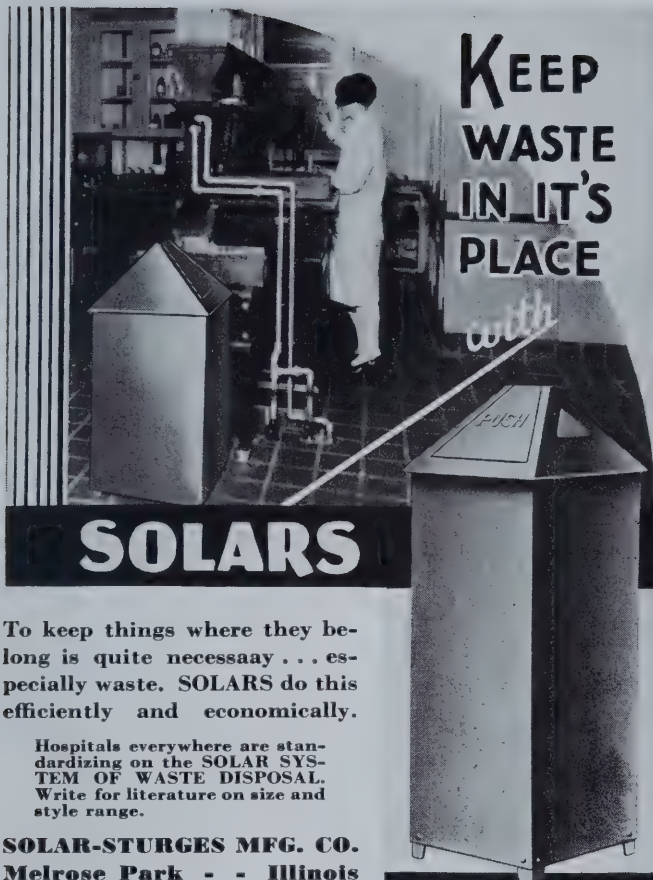
H. C. Hemmingway & Company is freezing peas, corn, spinach and cherries, which are being sold at retail in various cities, and are finding ready acceptance in the institutional trade.

Its ability to maintain flavor is one of the chief reasons why freezing is meeting with success as a method of preservation. So far as possible, products are frozen at the moment when their flavor is best, whether it be immediately after picking, as in the case of most fruits and vegetables, or some time after killing, as in the case with meats. When defrosted, these products still have the flavor which characterizes them when they were frozen and it is because of this characteristic that they are finding such ready popular acceptance.

SIMPLIFY LAUNDRY EQUIPMENT

The required degree of support by the industry has been accorded simplified practice recommendations covering commercial laundry extractors, ironers, tumblers and washers, respectively, according to an announcement by the division of simplified practice of the Bureau of Standards. The simplified schedules for washers and tumblers are concerned with the size, the type of drive, the number of compartments, the number of cylinder doors, and the number of vertical and horizontal partitions. The tumbler program also provides for the method of heating. Types and diameters are considered in the extractor recommendation, and sizes, types, drive, and method of heating are contained in the flatwork ironer program. These recommendations, which were proposed and developed by the industry, were effective on October 1.

HOSPITAL MANAGEMENT for October, 1932



**KEEP
WASTE
IN ITS
PLACE**

with

SOLARS

To keep things where they belong is quite necessary... especially waste. SOLARS do this efficiently and economically.

Hospitals everywhere are standardizing on the SOLAR SYSTEM OF WASTE DISPOSAL. Write for literature on size and style range.

SOLAR-STURGES MFG. CO.
Melrose Park - - Illinois

The Skill of the Specialist

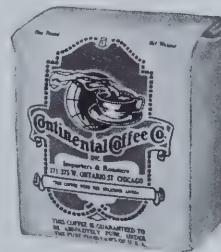


—detects hidden meanings in a
CARDIOGRAPH

THE trained eye and mind of the heart specialist quickly analyze a cardiograph, and enable him to make an accurate diagnosis from his findings. Here, again, the value of specialization is made sharply evident—not alone in the treatment of heart cases, but in the constant addition to the total fund of heart knowledge.

—rejects hidden imperfections
in
COFFEE

AT every stage in the production of Continental Coffee, the skill born of specialization forms a barrier against inferiority, and assures a coffee pre-eminently suited to the needs of hospitals, clubs, and institutions. This famous blend produces a beverage which cheers and comforts the patient, and offers pleasurable refreshment to the staff. May we send you a trial order of 10, 20 or 30 pounds on a money back guarantee?




Continental Coffee Co.
INC.

"The Coffee with the Delicious Aroma"

IMPORTERS ROASTERS

371-375 W. Ontario St., Chicago, Ill.



NITROUS OXIDE CARBON DIOXIDE
OXYGEN CARBON DIOXIDE &
ETHYLENE OXYGEN MIXTURES

TIME TELLS!

In the last twenty years in America every so often some new form of anesthetic has been put on the market, sometimes with most startling claims. Most of them vanish as rapidly as they come, because they cannot stand the test of time.

It was just about twenty years ago that NITROUS OXIDE AND OXYGEN first came into real use as a major anesthetic. Today, supplemented by ETHYLENE and CARBON DIOXIDE gases, they are more largely consumed than ever before, and the consumption is constantly growing. THE USE OF THESE PRODUCTS HAS STOOD THE TEST OF TIME.

Back of the Puritan Maid label on each and every cylinder identifying the products of the Puritan Compressed Gas Corporation is the reputation of eighteen years in the field. For safety reasons we differentiate our gases with distinctive colors over the entire cylinder, as recommended by the resolution of the International Anesthesia Research Society.

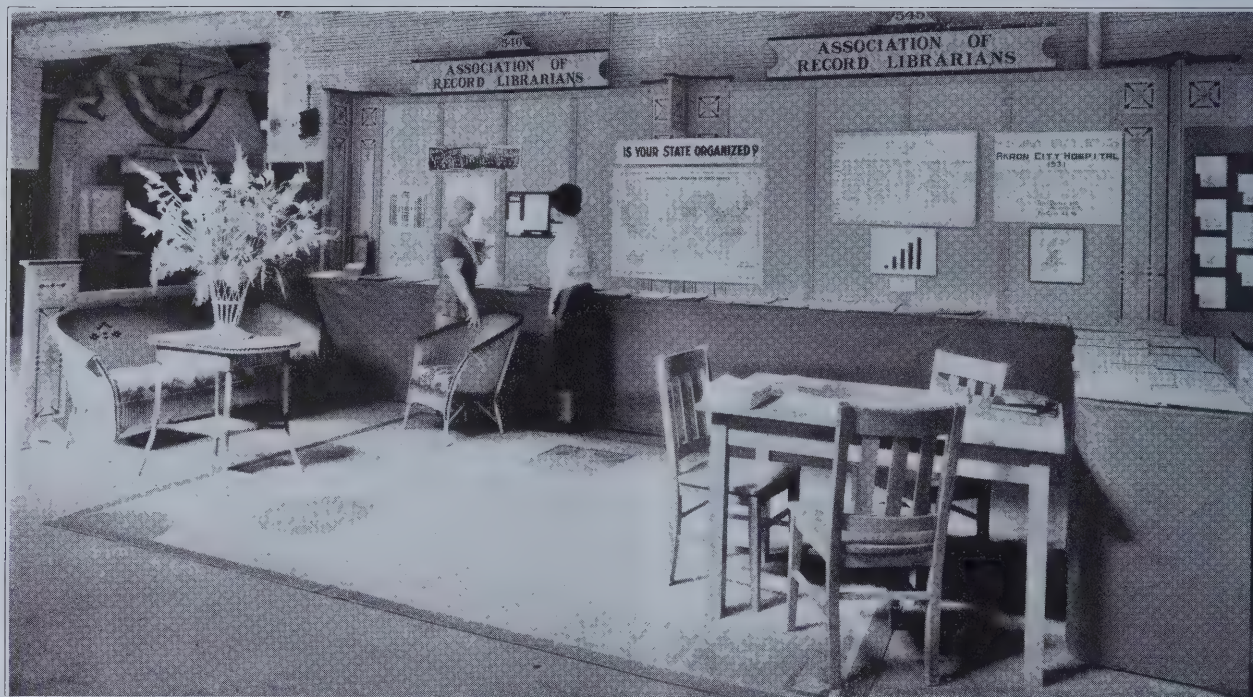
We also offer Anesthetic Equipment, Pressure Reducing Regulators, Bedside Stand Inhaling Outfits, Noiseless Roller-Wheeled Cylinder Trucks, Oxygen Tents, Resuscitation Apparatus, and Wilson Soda Lime.

PURITAN COMPRESSED GAS CORP.

Kansas City	Cambridge, Mass.	Chicago
2012 Grand Ave.	13 Charles St.	1660 So. Ogden Ave.
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St. Paul		St. Louis
810 Cromwell Ave.		4578 Laclede Ave.

Write for your copy of our latest booklet, "The Real Story of Oxygen for the Medical Profession." Also catalogues of Latest Oxygen Tents.

The Record Department



This attractive display of the Association of Record Librarians of North America created a great deal of interest at the A. H. A. convention in Detroit.

Narcotic Record System at Crouse-Irving

By Dorothy Pellenz

Executive Secretary, Crouse-Irving Hospital, Syracuse, N. Y.

THE question of accurate and complete narcotic records is one that interests every hospital. A hospital is not only bound to have available for inspection by federal officers complete proof of the exact use to which all narcotics have been put, but for its own benefit is anxious to know that its narcotic supply is being safeguarded from waste, theft or misuse.

CROUSE-IRVING HOSPITAL		NARCOTIC RECORD		DRUG <i>Morphine gr. 1/4</i>		Page No. <i>1</i>	
<i>Second</i> Floor							
Date	Time	Patient	Address	Doctor	Name	Dose	
1 July 1	10.15 AM	Jones, Mary	820 W Genesee St.	Smith	E. Black	1 1/4	
2	5.30 PM	Brown, John	520 S Salina St.	Jones	L. White	1 -	
3	6.00	Green, Robt	1020 James St.	Murphy	E. Black	1 -	
4	10.00	Hall, Albert	520 E Jefferson	Andrews	L. White	1 -	
5	11.30	Reed, Mary A.	790 Court St.	Wallace	M. Nelson	1 -	
6 July 2	12.15 PM	Hibbard, Jane	215 E Onondaga	Trotter	E. Smith	1 -	
7	1.50	Howe, Richard	720 McCrory Ave.	Raymond	E. Smith	1 -	
8	4.30	Stone, Eliza	450 University Ave.	Andrews	E. Smith	1 -	
9							

NARCOTIC RECORD SHEET

Narcotic record sheet of second floor for morphine gr. 1/4. (See accompanying requisition form in illustration No. 2.) Note that each dose is numbered, as well as each page. This insures a quick and accurate identification of each dose.

The line drawn under dose 8 indicates that the items above have been accounted for to the pharmacy. This is for the convenience of the supervisor and the pharmacist. The items from No. 1 to 8 constitute the first entry on the requisition sheet in illustration No. 2.

Since an enormous number of narcotic pills are used annually by even a small general hospital, the labor of making the necessary records should be kept to the minimum consistent with accuracy.

Four years ago Crouse-Ingving Hospital decided to revise and simplify its narcotic records. After much study it evolved a system which provides an accurate control and which is simple and economical to operate.

Each hospital department is allowed a certain stock of the various sizes and kinds of narcotics, which is charged against it and which must be accounted for before the supply is replaced.

Each department also has a special loose-leaf narcotic

REQUISITION AND RECORD OF NARCOTICS RECEIVED AND USED
Second Floor
DRUG *Morphine gr. 1/4*
Page *1*

ON HAND		NARCOTICS USED (As per Narcotic Record Book)		Bal. at time of Req.		REQUISITIONS		TOTAL		Checked and issued by	
Date	Amt.*	Page	From	To	Total Used	Date	Amt.	Forward			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1931 July 1	12	1	No.	No.	8	8	4	Jul 3	12	16	B.M.B.
July 3	16										

NARCOTIC REQUISITION SHEET

Narcotic requisition sheet of second floor for morphine gr. 1/4. (See accompanying record sheet in illustration No. 1.)

Note how the first entry checks up with the narcotic record sheet. At the time of the next requisition, the supervisor will have to account for 16 tablets.

Column 6 is used to explain discrepancies, such as pills broken or destroyed.

SUMMARY

Column 2 (Amount on hand)
Less Column 7 (Amount used, per record sheet)
Equals Column 8 (Balance at time of requisition)
Plus Column 10 (Amount received on requisition)
Equals Column 11 (Amount forwarded, to be accounted for at next requisition)



Over two thousand
hospitals use
our forms

Superintendents

should have our

**CATALOGS
and FREE
SPECIMENS**

of

Charts and Records

AMERICAN COLLEGE OF SURGEONS
(Standardized Records)

CATALOG No. 10 (100 Miscellaneous Forms)

TUBERCULOSIS RECORDS

OCCUPATIONAL THERAPY RECORDS

VALUABLE RECORD BOOKS

HOSPITAL STANDARD PUBLISHING COMPANY

40-42 S. PACA STREET - BALTIMORE, MD.

Write for samples : : Sent on request

READ



Model No. 60
Adjustable—
Standard Size
38" long

THEY
COST LESS
ultimately
than ordinary
Rubber Sheeting

GIVE
ABSOLUTE
MATTRESS
PROTECTION!

CANNOT
WRINKLE
OR CRACK!

ELIMINATING
the usual discom-
forts patients are
subjected to.

for rigid
Economy
and
humane
Performance

Equip your beds
with *the original*

**NORINKLE
RUBBER
SHEETS**

Accept No Substitute!

There is a NORINKLE
MODEL TO MEET
EVERY PROBLEM

HENRY L. KAUFMANN & CO.

301 CONGRESS ST.

BOSTON, MASS.



Nearly three hundred years ago Jeanne Mance selected a site at the foot of Mount Royal on the island of Montreal and superintended the construction of a building of rough hewn timbers—the Hotel Dieu that was to serve as hospital to the little colony of Villemarie. On the same site today stands a modern and more imposing Hotel Dieu—a monument to the determination and fearlessness of the gentlewoman who left wealth and comfort in France to face danger and privation in the wilderness of Canada.

Through siege and pestilence and famine, often suffering from actual want, Jeanne Mance never faltered. Her devotion, enthusiasm and courage won for her a secure place in history and gave to Nursing another heroic figure.

WILL ROSS, INC., WHOLESALE HOSPITAL SUPPLIES
779-783 N. Water Street Milwaukee, Wisconsin

Nursery **NAME NECKLACE**

Baby Identification

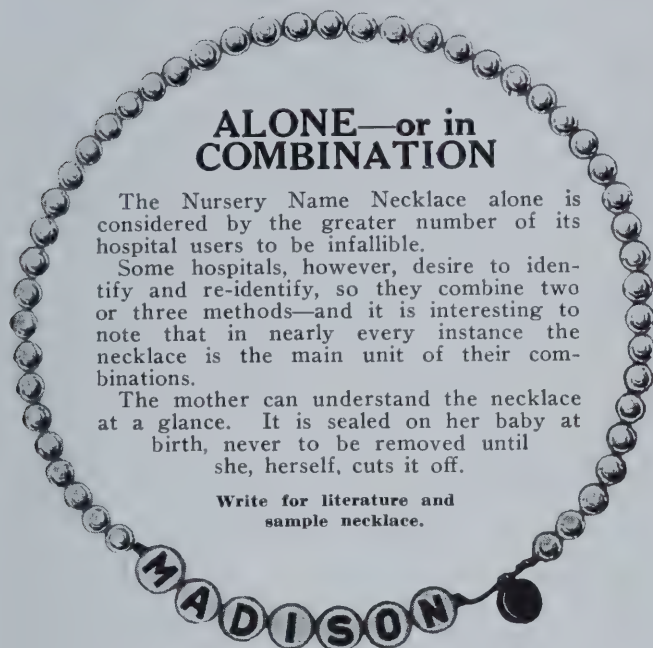
ALONE—or in COMBINATION

The Nursery Name Necklace alone is considered by the greater number of its hospital users to be infallible.

Some hospitals, however, desire to identify and re-identify, so they combine two or three methods—and it is interesting to note that in nearly every instance the necklace is the main unit of their combinations.

The mother can understand the necklace at a glance. It is sealed on her baby at birth, never to be removed until she, herself, cuts it off.

Write for literature and sample necklace.



J. DEKNATEL & SON, INC., 96th AVENUE
Queens Village (Long Island), New York

SAFETY—COMFORT—ECONOMY



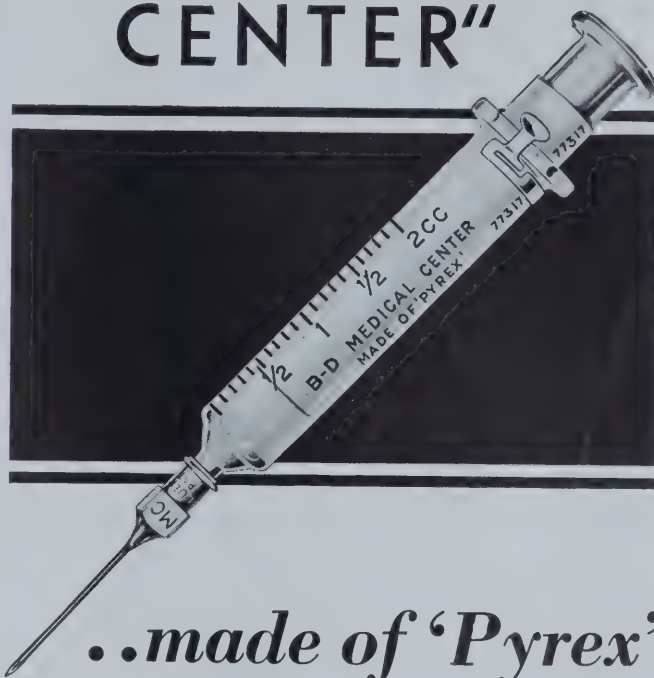
THE POWERS SHOWER MIXER

IN thousands of hospitals, nurses' homes, schools, clubs, hotels, and homes this remarkable SAFETY mixer is replacing ordinary mixing valves because it prevents sudden "shots" of cold or scalding water due to the use of nearby faucets, flush valves, etc.

Write for Book. The Powers Regulator Co., 2715 Greenview Ave., Chicago, 231 E. 46th St., New York—also in 41 other cities.

A New B-D Syringe

"MEDICAL CENTER"



..made of 'Pyrex'

With the superior features of the **B-D** Yale Syringe at no advance in price.

It will stand more than 150 hours of continuous sterilization.

It has an extra strong needle tip and comfortable, strong finger grip.

The bottom of the barrel is reinforced to reduce breakage.

Its use assures you of satisfactory syringe service for a long period at a very low cost.

Sold Through Dealers

B-D PRODUCTS

Made for the Profession

Makers of Genuine Luer **B-D***, Luer-Lok* and **B-D*** Yale* Syringes, Erusto* and Yale* Quality Needles, **B-D*** Thermometers, Ace* Bandages, Asepto* Syringes, Armored **B-D*** Manometers, Spinal Manometers, and Professional Leather Goods.

*Trade marks of Becton, Dickinson & Co.

BECTON, DICKINSON & CO., Rutherford, N. J.



"We are pleased with the dresses and monograms and . . . are very happy over having selected the white uniform . . . The hospital and students will realize how much more comfortable, good-looking and economical the white uniform is.

Thanking you for your prompt and efficient service, I am

Very truly yours,

Supt. of Nurses

White for Student Nurses is Gaining Favor..

The above excerpt from a recent letter is a typical expression of the economy and general satisfaction which many hospitals are experiencing with the new all-white uniforms for student nurses. We would like to tell you more about this trend towards the plain white garment which eliminates the laundering of bibs, aprons, collars and cuffs, and cuts costs.

Mail the Coupon today.

SnoWhite Garment Mfg. Co.
946-948 N. 27th St. Milwaukee, Wis.

SNOWWHITE

TAILORED UNIFORMS

SnoWhite Garment Mfg. Co.,
946-948 N. 27th Street, Milwaukee, Wis.

Tell us more about the trend towards white.

Name

Address

City..... State.....

Hospital

X-RAY; LABORATORIES

Progress in X-ray Equipment

The paper X-ray "film" is now on the market and is being investigated by institutions whose bills for films have become increasingly burdensome. It is doubtful if these will displace the cellulose films, but radiologists appear to believe they will be useful for certain types of work. For taking X-rays of large groups, quickly, such as health department work in X-raying the chests of school children, the paper films may be purchased in continuous rolls, used somewhat in the manner of the common kodak film and later developed as a unit. This plan is said to decrease markedly the cost of such X-ray work.

X-ray machines are constantly being improved. The noiseless valve tube machine has apparently come to stay. Fluoroscopic tables have been further safeguarded against danger of electric shock to patient and operator, and some models are equipped with motors to raise and lower the table to any desired position between the horizontal and the vertical. A "consultation" stereoscope is available which permits the teacher and student or two physicians to study and discuss, together, a single set of stereoscopic films. Dental X-ray machines have been improved and simplified; they are made for convenient wall attachment in the dental clinic for use with the patient in the dental chair. The ones which have safeguards against electric shocks are more in demand. The general use by dentists of X-ray machines is less desirable from the point of view of quality of results than a plan which puts all such work in the radiology department, but the saving in time and in effort in transportation of patients is a great advantage to the busy clinic.—From the 1932 report, A. H. A. committee on hospital planning.

"BEAD" SOAP IN THE LABORATORY

The old text books on bacteriological laboratory technique—in which the use of soap for the washing of test tubes, beakers, and slides was described—were written before the advent of quickly and completely dissolving soap. Experience had taught the earlier workers that hydrochloric acid could not be used on glassware without the formation of a dingy film when soap had been used, unless it had been rinsed a dozen or more times.

With the discovery of a new method of making soap, especially suited for the cleansing of glassware of all kinds, by spraying hot soap stock from high towers and drying the soap in the form of almost microscopic hollow beads, a product much more soluble than soap powders was obtained.

This "bead" soap, manufactured by the Colgate-Palmolive-Peet Company and known as Super Suds, has found ready acceptance in bacteriological and other laboratories because it permits the use of a soap as a detergent and at the same time permits its complete rinsing from glassware with 1 or 2 rinses.

Letters from the heads of laboratories, workers, and instructors tell of the many uses to which Super Suds is put.

"The Babcock milk test bottle," writes the head of a department of health laboratory, "usually one of the most difficult to clean, after a rinse in water to remove the sulphuric acid, then treated with Super Suds or a solution of it, rinsed in clear water again, is bright and sparkling as new, instead of the usually dingy, dirty brown."

"Super Suds, we have found, cleans serological glassware beautifully. Microscope slides and other laboratory glassware all respond to Super Suds, without the employment of various strong acid mixtures that are unsatisfactory for helpers to handle."

A laboratory instructor of nurses states, "Super Suds has made it possible for me to cultivate in the student nurses taking laboratory work a 'surgical conscience.'"

The rapid dissolving power, affording complete hydrolysis in even luke-warm water, and the avoidance of undissolved soap flakes adhering to glassware, together with the ease of rinsing with only one or two rinses of clear water, have given Super Suds its welcome by the laboratory technician and the "beaker boy" alike.

No longer need bedside radiography be of a compromising quality

*Development of the Victor Model "D"
Mobile Shock-Proof X-Ray Unit over-
comes the difficulties experienced here-
tofore with mobile X-Ray apparatus*

THE Hospital Roentgenologist, superintendent and entire staff—all will appreciate the significance of this timely development.

X-Ray diagnosis of the bedridden patient—in room or ward—is quite as important as of patients who can be handled in the main x-ray laboratory, and often more so. Experience has shown, however, that under these conditions the roentgenologist has too frequently found diagnosis difficult, due to inaccessibility with bedside x-ray equipment available up to now.

Because the Victor Model "D" Mobile Unit is *shock proof*, no restrictions are imposed on the operator in his desire to obtain the best diagnostic view of the part under observation. There are no exposed high tension parts to be avoided, consequently the utmost flexibility is afforded in obtaining preferred position of the tube, irrespective of metal parts of the bed or other current conductors adjacent. In the operating room, too, this feature is important.

With the Model "D" Mobile Shock-Proof X-Ray Unit, bedside x-ray diagnosis becomes remarkably simplified, with a quality of work that compares with that produced under far more favorable conditions in the main x-ray laboratory.

What more need be said, considering the trade-marks which the apparatus bears?

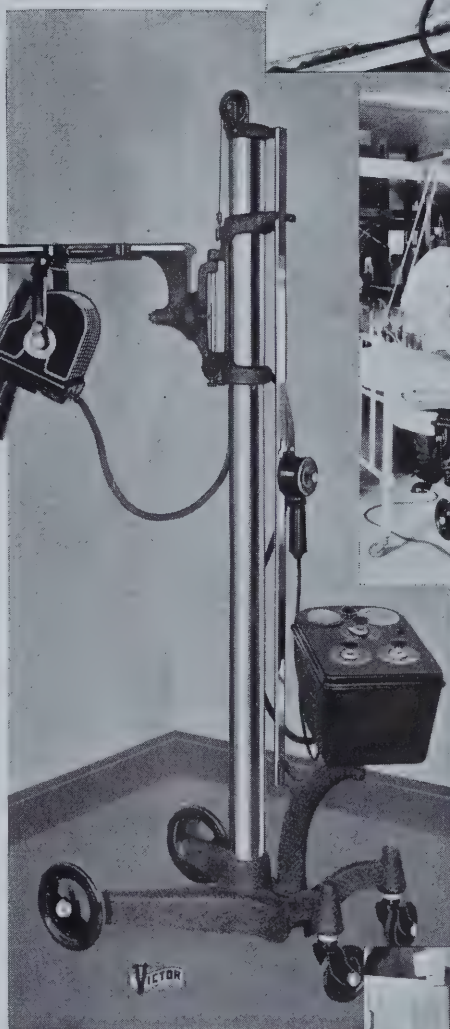
**GENERAL ELECTRIC
X-RAY CORPORATION**

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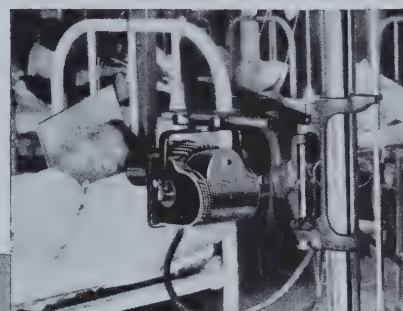
Chicago, Ill., U. S. A.

FORMERLY VICTOR X-RAY CORPORATION

Join us in the General Electric program broadcast every Sunday
afternoon over a nationwide N. B. C. network



Made under patents to Coolidge (No. 1408989) and Waite (No. 1334936—assigned to General Electric Company in June, 1919), and other patents and applications for patents.



For bedside
radiography and
fluoroscopy in
private rooms,
wards, and in the
operating room.



98

The Nursing Department

Advantages of Graduates

St. Joseph's Hospital, Brainerd, Minn., which for some years has offered graduate nursing service to its patients, recently was asked to comment on the advantages of graduate vs. student nursing service. The following remarks were offered:

"By conducting a hospital without a school of nursing we find that, although our expenses are practically the same as for that of training schools, our standards of nursing care are higher.

"The nursing field is crowded and we do not believe that the smaller hospitals, which cannot offer every educational facility, should conduct a training school. Give the graduate nurse who has the training a chance to render her services.

"Graduate nurses' services may be discussed through three points of view, namely, (1) that of the hospital, (2) the physician, and (3) the patient.

"Graduate nurses, whose skilled hands are able to take care of the responsibilities assigned them, are very plentiful at this time, and consequently the wages of a general duty nurse are lower. Where one employs competent instructors to train the student, one must expect to pay a substantial sum.

"The physicians of a hospital feel more at ease to know that their patients are under the care of people who have received all the training possible, many of the nurses having years of experience.

"The patients are assured of the best possible attention. The graduate nurse, knowing just what conditions may arise, is ever on the alert, thus being able to inform the attending physician and is therefore able to render every service possible to the hospitalized person."

AWAKEN PATIENTS LATER

"Due, I believe, to the many conveniences which we enjoy and the satisfactory arrangement of the wards, we found it a very simple matter to change our routine of long standing and allow the patients to enjoy an extra two hours' sleep," writes Helen M. Moir, directress of nurses, French Hospital, New York.

"Several early morning minor duties which had no direct relation to the patients were transferred to the night nurse, thus enabling all the day nurses to begin their patients' routine morning care immediately after the conference with the head nurse.

"Breakfasts are not served until 7:30.

"We met with no opposition and no inconvenience in making this adjustment and judging from the comments and expressions of appreciation from the patients, we are convinced that we have made a step in the right direction toward the comfort of our patients."

A NURSING UNIT

"Eleven graduate nurses and a dietitian compose the staff of the school for nurses," writes Lucretia Mott Guss, directress of nurses, regarding the children's unit of St. Luke's and Children's Homeopathic Hospitals, Philadelphia, in a recent bulletin. "Each has a course of duty expressed in the titles they bear, as follows: directress of nurses, instructress of nurses; first assistant directress of nurses; second assistant directress of nurses; night supervisor; assistant night supervisor; supervisor of maternity department; supervisor of operating room; supervisor of medical children's wards; supervisor of adult and children's surgical wards; and supervisor of nursing dispensary.

"There are forty-one pupil nurses in the school, thirty-nine of them students and two are affiliated students from the St. Luke's unit, who affiliate in the children's unit for pediatrics and obstetrics.

"The students of the school are classed as follows: seven seniors, thirteen intermediates, fourteen juniors, and five proba-

tioners. These nurses are distributed throughout the hospital. Nine serve in the maternity department, three in the operating room, two in the pediatric diet laboratory and one in the diet kitchen. Three are affiliated at the Hahnemann Hospital for adult surgical, medical private duty service, and gynecological duty. Eight are assigned to adult and children's surgical services and seven to children's medical service. Six nurses are on night duty.

"The students have a liberal, social and athletic life. These activities are not haphazard but are ordered and arranged by the faculty and are chaperoned and directed as required. The students have opportunities to attend the theatres, and hear the best music the city affords. School dances are held in the winter time, and the students are thus given a pleasant and diverting social contact. There are corresponding diversions for the summer time, arranged and directed by the school heads. The women's organizations of the hospital and many individual friends invariably respond generously in defraying the financial expenses of these affairs.

"A unique social diversion for the students is provided by the graduate nurses of the school. The graduates on two evenings a month tender the undergraduates a card party, in which the student nurses who have a liking for cards are taught to play bridge and other card games. There are also classes for those who desire to learn to swim, and facilities are also provided for natatorial sport.

"The student body is looking forward to having a well-equipped gymnasium as an adjunct to the new nurses' home, with provision for basketball, bowling, physical training, etc."

UNIVERSITY NURSING COURSE

The Catholic University of America, Washington, D. C., has begun a course in nursing education with the current school year, owing to the interest that was displayed in the summer course this year. The academic year course is open only to graduates of a nursing school of approved standing. Special instructors in nursing education are Sister Mary Olivia, O. S. B., R. N., B. S., A. M., former superintendent, St. Mary's Hospital, Duluth, and principal of St. Gertrude's School of Arts and Crafts, Washington, and Sister Mary Berenice, O. S. F., R. N., Ph. R., B. S., M. A., director of St. Joseph's School of Nursing, Milwaukee.

INTERNATIONAL PROGRESS

The International Hospital Association has already taken a very satisfactory development notwithstanding the world-wide economic depression, says a recent announcement. Up to the present, 15 national hospital associations have joined. Five of the 11 study committees organized have brought their preliminary work to such a point that it has been possible to print their program in the second number of the third year of "Nosokomeion." This quarterly is the official organ of the Association and is edited in Stuttgart by W. Kohlhammer.

HEALTH EDUCATION INSTITUTE

The first Institute on Health Education to be conducted by the Public Health Education Section of the American Public Health Association will be held at the Hotel Willard, Washington, D. C., October 22, 23 and 24, immediately preceding the annual meeting of the Association, which opens Monday, October 24. The purpose of the Institute is to provide instruction in the content and methodology of Health Education to a limited number of persons actively engaged in health education.

SEVEN NURSES IN FAMILY

When Alice Olsen completed her course in nursing at Clarkson Hospital, Omaha, she was the fifth daughter of the family to become a nurse, says a newspaper report. Others are: Mrs. Ida Murphy, superintendent, Harlan, Ia., Hospital; Mrs. Olga Moon, Omaha; Mrs. Edna Cotton, Exira, and Alma Olsen, Marion, Ind. Two sisters-in-law, Mrs. Viggo Olsen and Mrs. Ted Olsen, of Omaha, also are nurses.

COST OF STUDENT NURSES

"The cost for each student in the nursing school for the first five months is \$320," says the report of Grace Hospital, New Haven, Conn. "If the student leaves at the close of five months she has cost us, exclusive of instructors' salaries, exactly \$260. For that reason it would seem advantageous to charge for the pre-clinical course."

Is the cat unit potency printed on them?

• • • AN ECHO FROM DETROIT

AT the A.H.A. Convention practically every hospital executive who visited the Roche exhibit wanted full information on Digalen Injectable. For two good reasons:

1. Each ampul bears a definite statement of potency in terms of cat units.
2. Economy.

Because it is the digitalis ampul issued with potency definitely expressed in cat units on its label, the method of assay preferred today by most cardiologists, and because this Roche ampul is sold direct to hospitals at the lowest price of \$5.00 per C, leading institutions everywhere are now turning to the use of Digalen Injectable exclusively.

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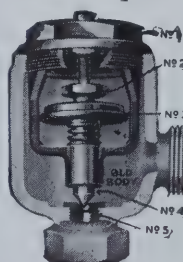
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THE HOSPITAL LAUNDRY

Own Laundry Pays, Even With Low Census

"We made some laundry figures in July and thought they might be of interest," writes Clarence H. Baum, superintendent, Lake View Hospital, Danville, Ill. "July was a light month on account of the low census.

"We did 10 tons of flat work, a total of 65,538 pieces. In addition to this we did 4,888 pieces of hand ironing. We had 163 shirts for doctors, 134 pants and 13 coats. We have an apron which is gathered at the top and requires hand ironing; we use this as it makes a much better appearance, but I am wondering if it would be better to have an apron which could be ironed on the mangle as we do on an average of 400 of these a week.

"The total cost for this work—payroll, supplies, etc.—was \$421.64. We had a local laundry go over our list and the best offer he could make for this work was \$1,124. He said he would have to put on five extra girls and a man in the wash room to do our work and he would not sort our linen; we would have to do this here. Inasmuch as we had to take care of our isolated linen, sort the linen, etc., it seems we are making quite a saving in running our own laundry.

"We find our daily linen classifies as follows:

"31 different pieces daily for floors.

"18 different pieces daily for nursery.

"29 different pieces daily for dining room.

"30 different pieces daily for operating room.

"9 different pieces daily for laboratory.

"8 different pieces daily for physiotherapy.

"11 nurses' home twice a week."

Laundry in a Sanatorium

The Country Sanatorium of Montefiore Hospital, New York, for the year of its latest report averaged 223 patients, and the operation of its laundry is represented in the following figures:

Pieces washed, 432,150

Pieces repaired, 37,909

Pieces made, 1,158

New pieces distributed, 2,927

Soap, pounds, 3,799

Soda, pounds, 900

Starch, pounds, 420

Neutralizer, pounds, 86

The cost of supplies, according to the report, was \$794.22, and wages amounted to \$6,450.48.

Ten persons were employed in the laundry.

Dr. Arnold Shamaskin is medical superintendent of the Country Sanatorium, and Dr. E. M. Bluestone is director of Montefiore Hospital.

A NARCOTIC RECORD SYSTEM

(Continued from page 68)

ancy. If any particular department should have continual difficulty with "destroyed" tablets, the requisition must be approved by the superintendent.

Incidentally, each department is given only a limited supply of any narcotic. Experience has proved that by being forced to requisition fairly often, the floor supervisor has a closer check on her supply and can more easily trace a missing dose. Most of the supervisors check the narcotic cabinet daily. Thus if a dose has escaped listing, it is quickly located. A leak or theft in any department would be soon discovered by this method. Needless to

say, the narcotics are kept in a locked cupboard, the key to which is in the possession of the supervisor or any assistant she may leave in charge.

The record sheets are of twenty pound bond stock, of standard letter size, and are punched to fit into a loose-leaf *Narcotic Record Book*. Both sides of the sheet are used. The blanks for each kind of narcotic are separated in the book by an index guide, so that reference can be made very promptly to the desired record.

When the narcotic record and requisition sheets are completely filled, they are given to the pharmacy, which keeps them on file. This avoids a bulky record on the floor and insured the safety of the completed forms.

The pharmacy check of the various narcotics issued to the floors insures a perpetual inventory. The pharmacy also has a separate blank for each type of narcotic.

THE HOSPITAL CALENDAR

American College of Surgeons hospital conference, St. Louis, Mo., October 17-21.

Ontario Hospital Association, Toronto, October 26-28.

American Dietetic Association, New York, November 7-10.

Clinic Managers Conference, Mankato, Minn., October 13-14.

Colorado Hospital Association, Colorado Springs, November 8-9.

Mississippi Hospital Association and Mississippi State Medical Association, Jackson, April 10, 1933.

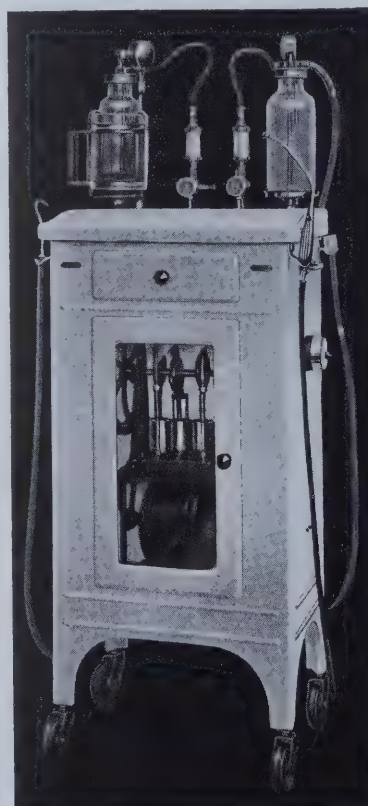
Iowa Hospital Association, Marshalltown, April 19-20, 1933.

Illinois-Indiana-Wisconsin joint conference, Chicago, May 3-5, 1933.

South Dakota Hospital Association, Sioux Falls, 1933.

Western Hospital Association, Long Beach, Cal., 1933.

American Hospital Association, Milwaukee, Wis., September 11-15, 1933.



A Complete Anesthetizing, Pressure and Suction Unit, consisting of 1/16 horse-power, motor-driven, four-cylinder pump—two cylinders for suction, and two for pressure; 32 oz. suction bottle, and 16 oz. ether bottle with hot water warming jacket held by Snap-Fit holders—an exclusive feature of Sorenson equipment.

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ANESTHETIZING, PRESSURE AND SUCTION OUTFIT

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check, money order, or cash in full payment.

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(D) SCIENCE INSTRUCTOR for 200-bed approved hospital, located in large midwest city.

(E) SUPERVISORS: Pediatric, for 30-bed department of large eastern hospital; \$90. (2) Obstetrical, 100-bed hospital, northwest. (3) Operating room, for small approved hospital, New York, \$100.

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You'll be surprised at the cost, even when compared with 1932 prices.

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HOSPITAL MANAGEMENT

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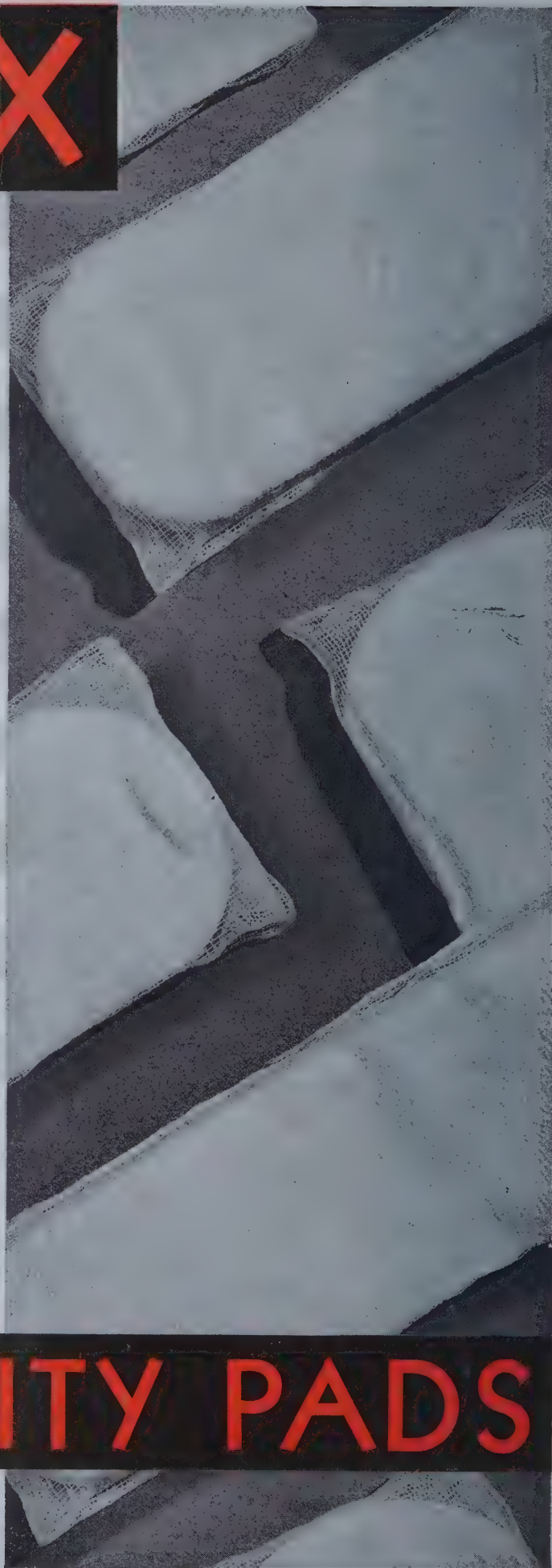
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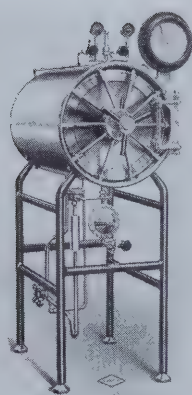
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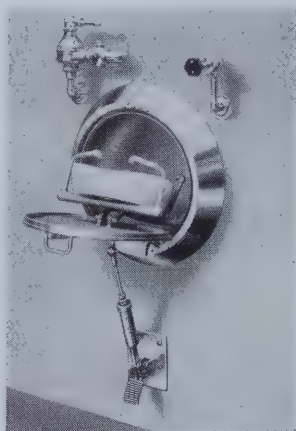
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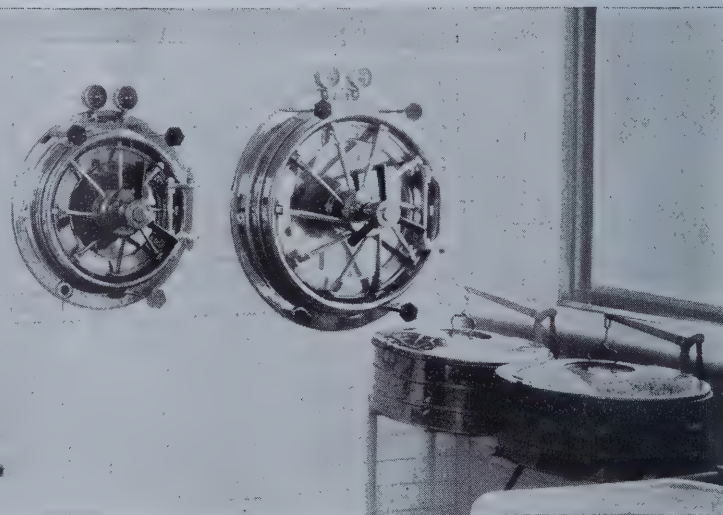
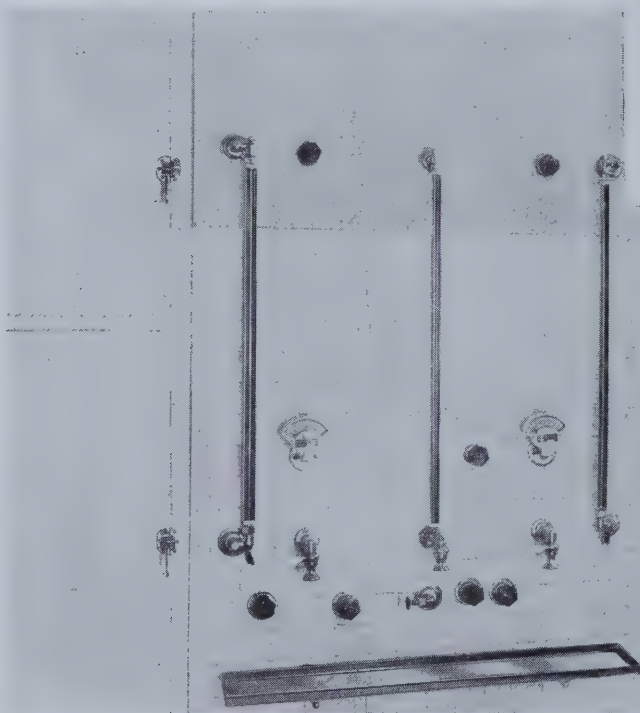
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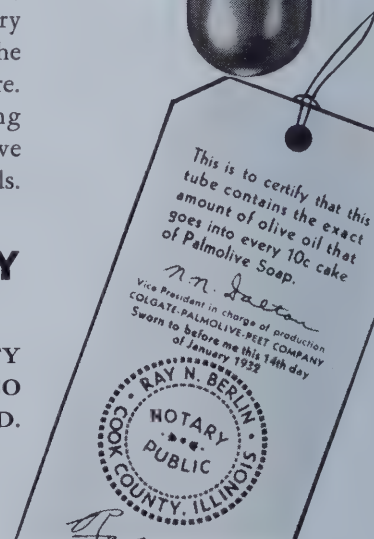
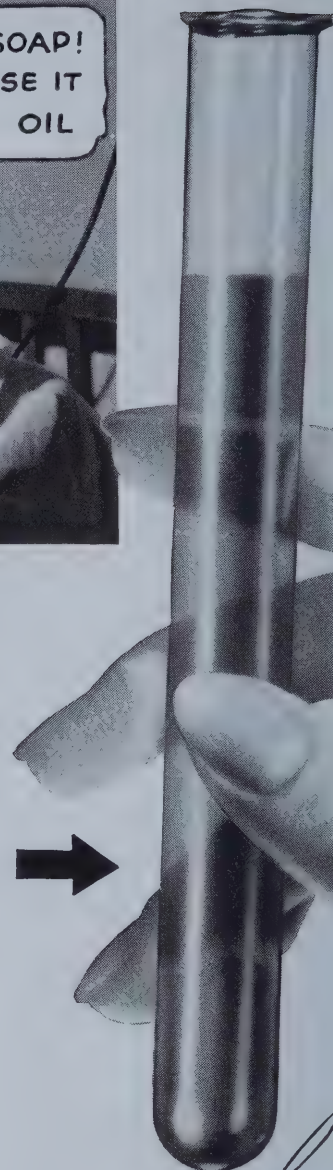
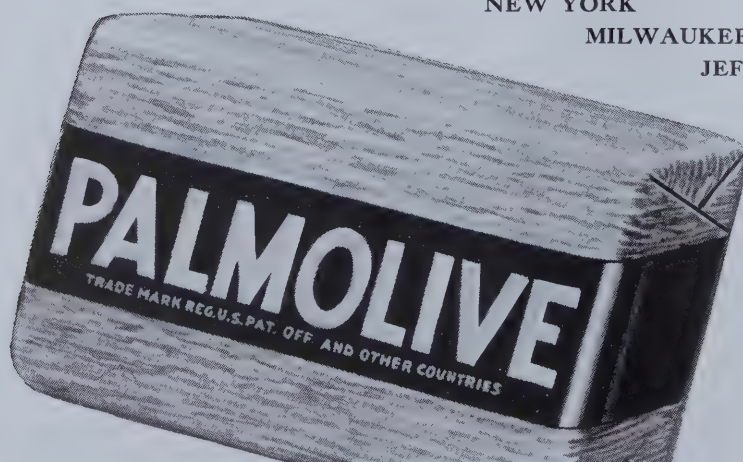
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HOSPITAL MANAGEMENT

A PRACTICAL JOURNAL OF ADMINISTRATION

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SEPTEMBER 15, 1932



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HOSPITAL MANAGEMENT for September, 1932

3

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* * *

Colt Autosan now offers a complete family of rack type dishwashing machines. Four new Colt Autosans—"R-2" and "R-4" shown below and their big brothers "R-6" and "R-8"—complete a line of seven rack type machines. One of them will fit your requirements perfectly—big enough for rush hour loads—economical in cost and floor space. Page 61.

* * *

Alcohol made from molasses is used for some purposes, alcohol made from grain is used for other purposes, and for the most exacting uses is made according to private specifications. A grade known by a definite brand name, or a specification alcohol should be and can be uniform. Page 18.

* * *

This new "ZO" Protective Holder opens or closes with a flip of the lid. It is dust-proof. It keeps your supply of "ZO" Adhesive absolutely clean and protected, yet ready for instant use. Third Cover.

* * *

This new instrument has been designed to meet the demand of research and medical workers for a semi-research microscope of moderate cost. It has a definite place in the laboratory of every hospital. Page 63.

* * *

So simple is the Nursery Name Necklace, with spelled out family surname—always visible—sealed on baby—that even mistrusting parents understand it confidently. Page 59.

* * *

What an opportunity to build good-will! In spite of its quality and prestige, Palmolive costs no more than ordinary soaps. Your hospital's name printed on the wrappers with orders of 1,000 cakes or more. Page 2.

* * *

Quality is the outstanding character of Castle Sterilizing Equipment. The price is based on how good we can make it. This reversal of the all

Advertisements are being read more closely now than ever before and for this reason manufacturers and sales organizations are trying to convey more practical and helpful information through their advertisements than at any previous time. Here are some excerpts from messages to hospital executives that are carried in the advertising pages of this issue.

too prevalent policy of building down to a price accounts for Castle installations in hospitals where compromise with quality is not tolerated. Second Cover.

* * *

Practically every important detail of progress in heat and humidity control apparatus has been of Johnson origin—today many features of essential mechanics and design are Johnson exclusively. Page 5.

* * *

It is significant that in these days when hospitals are reducing operating expenses, they are using Ready Made Dressings in greater quantity than ever before. Hospital administrators will find it worth while to study costs in test orders, to determine what can be accomplished in saving of waste in material and equipment and in more effective use of hospital personnel with Ready Made Dressings. Fourth Cover.

* * *

Next time you purchase serving, cooking or storage ware consider whether you are paying a price or purchasing value. It is important to remember that the recollection of quality will remain long after price is forgotten. Page 1.

* * *

Your investment of thousands of dollars in dishes and silverware requires the protection of safe cleaning. Brown stains on dishes and tarnish on silverware can be avoided by the use of Wyandotte Cherokee Cleaner. Page 13.

Continental Coffee is the product of a long specialization in supplying the coffee needs of hospitals, clubs and institutions. It is sure to earn the approval of staff and patients alike. Page 59.

* * *

There are imitations of the Ideal Food Conveyor. There are food carts that look very much like an Ideal unit—in size, general appearance, color and finish. But the Ideal itself cannot be duplicated. Many of the features of the Ideal are exclusive—protected either by license or our own patent rights. Many points of construction cannot be matched by small manufacturers with facilities unequal to ours. No maker can build and profitably sell a food conveyor unit for as little money as we can. Don't be influenced by talk of lower price—for there is no lower price, merit considered, than the Ideal price. Page 55.

* * *

The rigid cooking requirements of modern hospitals have inspired the making of Vulcan Gas Cooking Equipment. As a result, exactness of heat control, perfection in cooking and baking, reduced gas consumption, and a dependability demanded by hospital standards have been attained by Vulcan. Insert, page 56.

* * *

Now to the amazing strength and sensitivity of the Miller Anode Gloves there has been added a third and most important characteristic. The Miller Anode Gloves can now be had also with a new reinforced wrist. It will require no care in the putting on. Stretch it, yank it, drag it on, the Miller Anode's new wrist is virtually tear-proof. Page 11.

* * *

Back of the Puritan Maid label on each and every cylinder identifying the products of the Puritan Compressed Gas Corporation is the reputation of eighteen years in the field. For safety reasons we differentiate our gases with distinctive colors over the entire cylinder, as recommended by the resolution of the International Anesthesia Research Society. Page 59.

* * *

Do you training school records measure up to all of the standards and requirements? Are they complete in every detail? It is no longer necessary to spend both your valuable time and money to prepare individual records. Page 63.



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ARTERY—Straight needle ($\frac{3}{4}$ inch) on 000000 black silk.

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NERVE—Straight needle ($\frac{3}{8}$ inch) on 000000 black silk.

PLASTIC—Small, half-curved needle on 0000 Kal-dermic Skin Suture or black silk. Three-eighths circle needle on 000000 Kal-dermic Skin Suture.

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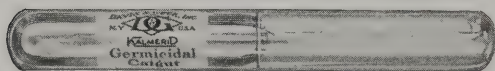
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1285.....40-DAY CHROMIC.....	1485

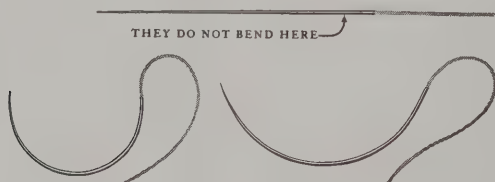
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WITH Atraumatic Needles integrally affixed to 20-day Kalmerid catgut. For gastro-intestinal work and membranes where minimized trauma is desirable.



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ANON-CAPILLARY, heat sterilized suture of unusual flexibility and strength. It is uniform in size, non-irritating, and of distinctive blue color. Boilable.



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Sizes: 000 00 0
(FINE) (MEDIUM) (COARSE)

In packages of 12 tubes of a kind and size

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(Identical in all respects to Kal-dermic skin sutures but larger in size.)

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CHROMICIZED to resist absorption for approximately thirty days.

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Each tube contains one tendon
Lengths vary from 12 to 20 inches

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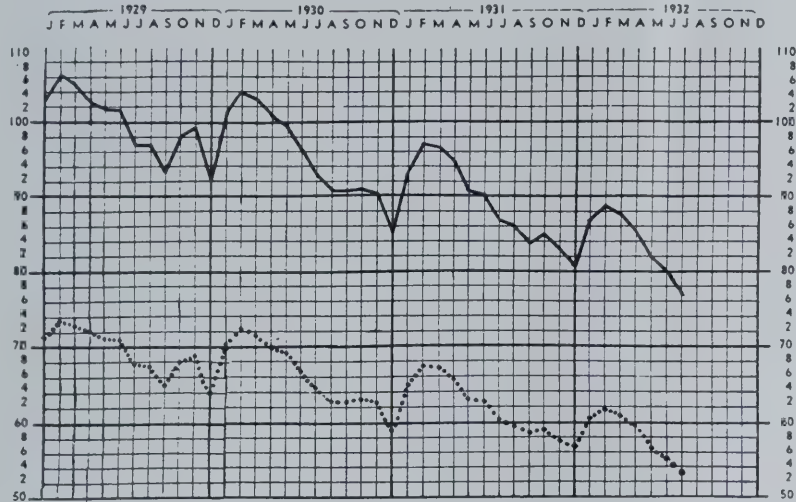
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"How's Business?"

HOW'S BUSINESS?

A composite picture of the percentage of occupancy in 91 general hospitals located in 87 communities in 35 states, corrected for normal growth.



Here Are Figures From Which Occupancy Chart Was Constructed

THE following figures are the basis of the hospital occupancy chart reproduced at the top of this page. These figures were supplied by 91 general hospitals in 87 communities of 35 states, with a basic bed capacity of 16,922.

The first group of figures represents actual number of beds occupied; the second group, receipts from patients; the third, operating expenses of the hospitals for each month since the "How's Business" graphs were begun, and the fourth, occupancy, using 100 per cent as the base.

TOTAL DAILY AVERAGE PATIENT CENSUS

November, 1928	11,533
December, 1928	11,040
January, 1929	11,919
February, 1929	12,335
March, 1929	12,253
April, 1929	12,114
May, 1929	11,981
June, 1929	12,025
July, 1929	11,473
August, 1929	11,548
September, 1929	11,157
October, 1929	11,590
November, 1929	11,736
December, 1929	10,977
January, 1930	12,048
February, 1930	12,425
March, 1930	12,408
April, 1930	12,128
May, 1930	12,044
June, 1930	11,601
July, 1930	11,290
August, 1930	10,997
September, 1930	11,015
October, 1930	11,086
November, 1930	11,005
December, 1930	10,524

January, 1931	11,510
February, 1931	11,991
March, 1931	11,970
April, 1931	11,669
May, 1931	11,251
June, 1931	11,187
July, 1931	10,765
August, 1931	10,657
September, 1931	10,409
October, 1931	10,499
November, 1931	10,266
December, 1931	10,145
January, 1932	10,758
February, 1932	11,038
March, 1932	10,888
April, 1932	10,596
May, 1932	10,082
June, 1932	9,927
July, 1932	9,571

RECEIPTS FROM PATIENTS

November, 1928	\$1,678,735.00
December, 1928	1,736,302.86
January, 1929	1,795,843.79
February, 1929	1,776,040.82
March, 1929	2,024,823.11
April, 1929	1,929,175.70
May, 1929	1,920,982.43
June, 1929	1,874,173.11
July, 1929	1,846,899.32
August, 1929	1,867,706.24
September, 1929	1,772,230.39
October, 1929	1,828,051.39
November, 1929	1,786,036.71
December, 1929	1,737,404.65
January, 1930	1,840,418.05
February, 1930	1,799,080.00
March, 1930	2,003,309.58
April, 1930	1,927,493.30
May, 1930	1,921,523.05
June, 1930	1,817,813.00
July, 1930	1,803,315.00
August, 1930	1,719,634.00
September, 1930	1,700,314.00
October, 1930	1,741,017.00
November, 1930	1,640,374.00
December, 1930	1,687,813.00
January, 1931	1,771,812.00
February, 1931	1,720,474.00
March, 1931	1,881,003.00
April, 1931	1,831,228.00
May, 1931	1,815,096.00

June, 1931	1,743,189.00
July, 1931	1,698,277.00
August, 1931	1,598,869.00
September, 1931	1,555,436.00
October, 1931	1,583,005.00
November, 1931	1,497,948.00
December, 1931	1,521,552.00
January, 1932	1,527,159.00
February, 1932	1,468,059.00
March, 1932	1,574,446.00
April, 1932	1,496,077.00
May, 1932	1,453,746.00
June, 1932	1,417,856.00
July, 1932	1,357,096.00

OPERATING EXPENDITURES

November, 1928	\$1,936,075.00
December, 1928	2,064,632.41
January, 1929	2,104,552.74
February, 1929	2,007,945.24
March, 1929	2,099,208.11
April, 1929	2,071,386.46
May, 1929	2,064,381.77
June, 1929	2,034,409.13
July, 1929	2,045,112.96
August, 1929	2,068,388.63
September, 1929	2,050,510.38
October, 1929	2,079,042.06
November, 1929	2,091,089.31
December, 1929	2,127,053.36
January, 1930	2,190,909.95
February, 1930	2,067,112.17
March, 1930	2,120,861.86
April, 1930	2,064,328.76
May, 1930	2,102,407.49
June, 1930	2,027,258.00
July, 1930	2,038,042.00
August, 1930	1,985,045.00
September, 1930	2,079,154.00
October, 1930	2,033,163.00
November, 1930	2,003,297.00
December, 1930	2,031,148.00
January, 1931	2,058,681.00
February, 1931	1,963,391.00
March, 1931	2,026,363.00
April, 1931	1,976,430.00
May, 1931	1,967,866.00
June, 1931	1,932,832.00
July, 1931	1,925,156.00
August, 1931	1,870,985.00
September, 1931	1,890,891.00
October, 1931	1,885,424.00
November, 1931	1,829,539.00
December, 1931	1,889,887.00
January, 1932	1,806,279.00
February, 1932	1,763,572.00
March, 1932	1,762,657.00
April, 1932	1,733,486.00
May, 1932	1,672,550.00
June, 1932	1,607,822.00
July, 1932	1,590,274.00

AVERAGE OCCUPANCY ON 100 PER CENT BASIS

November, 1928	69.6
December, 1928	66.5
January, 1929	71.6
February, 1929	73.8
March, 1929	73.2
April, 1929	72.2
May, 1929	71.2
June, 1929	71.3
July, 1929	67.8
August, 1929	67.5
September, 1929	65.0
October, 1929	68.0
November, 1929	68.6
December, 1929	64.0
January, 1930	70.1
February, 1930	72.1
March, 1930	71.8
April, 1930	70.0
May, 1930	69.4
June, 1930	66.6
July, 1930	64.7
August, 1930	62.7
September, 1930	62.8
October, 1930	62.9
November, 1930	62.4
December, 1930	59.1
January, 1931	64.9
February, 1931	67.5
March, 1931	67.2
April, 1931	65.8
May, 1931	63.0
June, 1931	62.6
July, 1931	60.3
August, 1931	59.7
September, 1931	58.3
October, 1931	59.0
November, 1931	57.5
December, 1931	56.8
January, 1932	60.2
February, 1932	61.8
March, 1932	61.0
April, 1932	59.3
May, 1932	56.4
June, 1932	55.6
July, 1932	53.6

Autumn Catalogs Tell of Newest Products

AUTUMN catalogs and booklets of manufacturers and distributors of hospital supplies and equipment are of special interest this year. A number of new leaflets were prepared for the A. H. A. and other conventions, and every superintendent and hospital executive should see these. Newer products reflect the demand for greater economy in operation and maintenance and there are many devices which actually will cut their cost in a short time with which some hospitals are not familiar. Check over the following list of new booklets and information circulars and ask for those that interest you:

Anaesthetics

No. 344. "Puritan Gas News," a publication of interest to all connected with anesthesia, gases, oxygen therapy, etc. Published by Puritan Compressed Gas Corporation. 532

No. 290. "Suggested precautions in the use of ether, ethylene and other anesthetics." Puritan Compressed Gas Corp. c30.

No. 347. "Recent Trends in Oxygen Therapy," a valuable brochure on the subject of oxygen as a therapeutic agent. Well prepared and published by Linde Air Products Company. 532

Cleaning Preparations, Soaps, Etc.

No. 326. "The story of soap," an intensely interesting booklet telling in story and pictures of the making of soap and soap products. Unusually well illustrated. The Procter & Gamble Co.

Beds, Mattresses

No. 345. "The Story of Slumberon, the Mattress Luxurious." An interesting and attractive folder describing the construction of Slumberon mattresses, and explaining its unusual features. The Rome Co., Inc. 532

Cubicle Equipment

No. 337. "Privacy in the Modern Hospital" is the title of a valuable booklet on cubicle screening published by H. L. Judd Co. After outlining the problems involved in securing privacy for ward patients, the booklet works out concrete solutions for many problems. c32

Disinfectants

No. 342. A table showing the amount of Lysol disinfectant and water necessary to make solutions of various strength, together with a description of the correct solutions to use for various purposes in the hospital. Also a dilution chart for use in the laundry. Lehn & Fink, Inc. 532

Flooring

No. 334. "Resilient Floors," an interesting photograph album showing Sealex floors designed and laid in recent years. Also contains a description of the many types of Sealex floors. Congoleum-Nairn, Inc. 232

General Equipment, Furnishings and Supplies

No. 327. Booklet describing professional uniforms for nurses and others, published by Henry A. Dix & Sons Corp. b0

No. 284. "Ten Kinds of Baths." Cannon Mills, Inc. b0

No. 261. "Nurses' Apparel and Hospital Supplies," a 32-page catalog. Marvin-Neitzel Corp.

No. 341. "SnoWhite Tailored Uniforms," and "SnoWhite Tailored Uniforms for Student Nurses," two booklets describing the complete uniform line of Sno-White Garment Manufacturing Company. Each style is well illustrated and completely described. 532

No. 323. "Standard ready dressings and supplies for

hospitals," a folder showing the styles, types and sizes of ready made products. Johnson & Johnson.

No. 328. "Curity Ready Made Dressings Manual," an interesting manual showing the complete line of ready made dressings, with descriptions of uses and other informative material. Lewis Mfg. Co. L31.

No. 329. The 1932 catalog of Will Ross, Inc. Attractively printed, well arranged catalog of the complete line of hospital equipment and supplies. L31.

No. 333. Numerous interesting booklets and pamphlets describing the therapeutic effects, the method of manufacture, and medical history behind many "Roche" drug products. Hoffmann-La Roche, Inc. 232

No. 336. "Cotton, Gauze and Adhesive Plaster—Their Manufacture and Application in Surgery," an exceptional booklet of 96 pages. Published by Johnson & Johnson. c32

No. 339. "Kalmerid Germicidal Tablets," a pocket-size leaflet describing the composition, efficiency and uses of this new product. Davis & Geck, Inc. 432

No. 340. A complete series of pamphlets, many of which, such as "The Mystery of Sleep," "Why the Cat Unit?" and "When Chemists Turned from Gold to Drugs," are especially useful in teaching materia medica to student nurses. Available in any quantity. Hoffman-La Roche, Inc. 432

No. 314. "How to Obtain Maximum Service from Hypodermic Needles and Syringes," an interesting, pocket size manual on the selection of needles and syringes for each kind of service. Also contains practical information on how to sterilize, clean, and care for these instruments. Becton-Dickinson Company.

No. 332. Bulletin No. 260, describing the Powers thermostatic radiator valve, a self-operating regulator designed for vacuum or vapor steam heating systems. The Powers Regulator Co. 132

No. 348. Kenwood Mills, Albany, N. Y., have prepared a folder containing swatches in color of blankets and rugs, together with all necessary information concerning these hospital products. This folder is most useful for reference.

Kitchen and Food Service Equipment

No. 331. "Good Coffee," a monthly publication of interest to all quantity users of coffee. Published in newspaper style and containing many hints valuable in the preparation of coffee. Continental Coffee Co., Inc. 132

No. 300. "The Perfect Tray," by Helen E. Gilson, Onandaga Pottery Co. d0

No. 276. Modern Kitchens. A 70-page booklet. International Nickel Company. C30

No. 252. "Scientific Hospital Meal Distribution." Swartzbaugh Mfg. Co., Toledo, O.

Laundry Equipment and Supplies

No. 277. Laundry Owners' Year Book. International Nickel Company, Inc. C30

Sutures and Ligatures

No. 338. "The Bacteriological Control of D. & G. Sutures," an interesting pocket-size folder describing the various manufacturing processes of sutures. Davis & Geck, Inc. 432

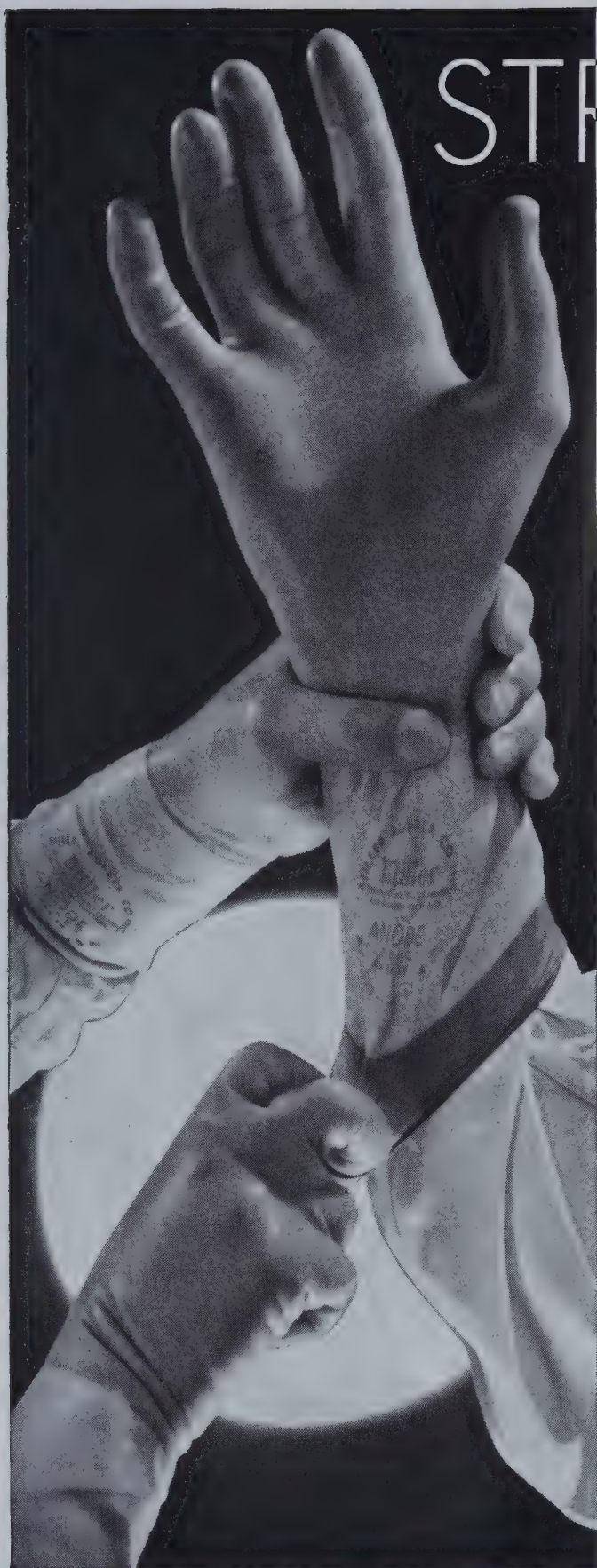
Sterilizers, Stills

No. 234. "American Sterilizers and Disinfectors." Catalog. American Sterilizer Company, Erie, Pa.

No. 213. "Sterilizing Technique Series." Five booklets. Wilmot Castle Company.

Surgical Instruments and Supplies

No. 322. "Handbook on Ligatures and Sutures," 1931 edition. An interesting booklet on the history, preparation, handling and use of ligatures and sutures, completely revised. Johnson & Johnson.



STRONGER- MORE SENSITIVE

**... and the Wrist is
virtually tear-proof**

DURING the past year, surgeons everywhere have enthusiastically adopted a new glove, the MILLER Anode, thinnest, yet strongest ever made.

It has freed their fingers from the heavy grip of old-time cumbersome acid-cured gloves. It has enabled hospitals to practice real economy on their glove accounts.

Now to the amazing strength and sensitivity of the Miller Anode Gloves, there has been added a third and most important characteristic.

The Miller Anode Gloves can now be had *also* with a new *reinforced wrist*. It will require no care in the putting on. Stretch it, yank it, drag it on, the Miller Anode's new wrist is virtually tear-proof.

Talk to your supply house representative. He will be glad to furnish samples. Test them for yourself. You will agree that the genuine Miller Anode Glove represents economy and safety in the operating room. You will recognize in the reinforced wrist, which you can have at your choice, an important contribution to efficiency.

MILLER ANODE GLOVES

{ *Certified to conform to commercial
standard specifications No. CS41-32.* }



OTHER MILLER HOSPITAL PRODUCTS — Anode Tonsillectomy Bags • Ice Caps • Invalid Cushions • Water Bottles Fountain Syringes • Anode Penrose Drains • Catheters Colon, Rectal and Stomach Tubes • Rubber Tubing.

Additional Services Hospitals May Render to Increase Revenue

DURING the depression we made a special rate during July and August for tonsils, of \$8 in wards, including laboratory work and 24 hours' care. We have also made a special rate of 10 days' stay in wards for appendicitis at \$35.

Another thing we did—we went over our entire plant and collected all of the junk, such as waste lead, old gas stoves, empty bottles, discarded wash basins, replaced steam tables, etc., and ran an ad in the local paper and sold over \$400 worth of this material.

Two of the girls in the office kindly gave their time and did personal collecting. They have been able to collect from \$25 to \$50 a week on old accounts. We find they are able to do this as they know the patients personally and the patients will pay them when they will not pay a professional collector.

Another way we saved was by cutting out about 10 telephones; that is, we cut out the nurses' school office phone and class room phone, and where some of the adjacent offices were each having a phone we combined the two in one phone.—CLARENCE H. BAUM.

AFTER a delay of nearly two years, during which time several attempts were made to enlist the support of the physicians in the organization of a committee for the study of malignancy, the Tacoma General Hospital will soon announce a cancer clinic to be held in the hospital on one morning of each week. It is believed by the management that such a clinic, ethically conducted, will finally overcome the fear on the part of the occasional physician now in opposition to a limited group of so-called experts taking business from him, and eventually enlist his support.

The meetings will be in charge of full-time hospital employees, the pathologist and radiologist, and will be open to any member of the staff. It is hoped that cases of interest will be available for presentation and discussion. As time passes, the active membership will probably be composed of those who attend most regularly and show the most interest. In the beginning, at least, the province of this clinic will be the study of cases and the careful and uniform taking of histories. It is hoped that in time the tumor group may act in a diagnostic and advisory capacity, and that the hospital itself may benefit through the admission of cases for treatment.—C. J. CUMMINGS.

IAM of the opinion that hospitals should be very careful in establishing departments bringing in revenue until they are assured that they are going to give to the public what the public demands.

I am not so sure that the "Hay Fever Clinic" is something to be patterned after by other hospitals. It is acknowledged that it is not a cure, but just a relief.

Some months back the writer was invited into a doctor's office and was conducted through the various rooms. He had established a physiotherapy department and had ten patients who were being treated by light. He had no trained person supervising the patients. This doctor was exploiting the public. At that time he was en-

joying a large practice. I have learned since my visit there that he has lost a greater percentage of his practice. The people lost confidence in him realizing that he was in business more for the money rather than for the desire of doing good.

As a hospital executive I shall act very cautiously in activities to increase revenues. I desire to keep the confidence of the people and in rendering any service to see that it is done with all sincerity.

Our county and city conducted a clinic under the supervision of the county physician. We proposed to take over the clinic for a stipulated sum. We also proposed to place in the clinic a public health nurse to do the school nursing in our public schools. Both propositions were accepted. We are using four to six of our student nurses in this department, giving them a good training as well as an understanding of real service and in rendering this service to our community we increase the confidence of our people in us and thereby increase our revenue.

I feel that in increasing our activities along such lines it is a real asset to our community and to our institution.—W. W. RAWSON.

IN regard to new departments, here is an excerpt from a recent notice to members of the staff of Wesley Memorial Hospital:

"Wesley Memorial Hospital is now in position to care for your cases of asthma and hay fever, whether of seasonal or perennial type. Several rooms are equipped with air filters and rubber-covered mattresses and pillows. These are ready for patients of all ages. This method of care is especially beneficial for the cases due to some inhalant factor, and prompt relief usually occurs in such cases."—PAUL H. FESLER.



Protecting Your Dishes

Your investment of thousands of dollars in dishes and silverware requires the protection of safe cleaning. Brown stains on dishes and tarnish on silverware can be avoided by the use of Wyandotte Cherokee Cleaner.

Scientifically developed exclusively for dishwashing, Cherokee Cleaner produces thoroughly clean dishes, protects them from stains, and costs less to use per thousand pieces.

For Cherokee is *all* cleaner. Every particle of it exerts a dynamic cleaning action. It completely removes fats and greases and then rinses away freely, leaving a sanitarily clean surface.

Cherokee Cleaner is definitely guaranteed to give you cleaner dishes at lower costs than you have ever before enjoyed.



***Order from your Jobber
today, or for detailed
information, write***

The J. B. Ford Company

Wyandotte, Michigan

***Wyandotte*
Cherokee Cleaner**



"We are pleased with the dresses and monograms and . . . are very happy over having selected the white uniform . . . The hospital and students will realize how much more comfortable, good-looking and economical the white uniform is.

Thanking you for your prompt and efficient service, I am

Very truly yours,

Supt. of Nurses

White for Student Nurses is Gaining Favor..

The above excerpt from a recent letter is a typical expression of the economy and general satisfaction which many hospitals are experiencing with the new all-white uniforms for student nurses. We would like to tell you more about this trend towards the plain white garment which eliminates the laundering of bibs, aprons, collars and cuffs, and cuts costs.

Mail the Coupon today.

SnoWhite Garment Mfg. Co.
946-948 N. 27th St. Milwaukee, Wis.

SNOWWHITE

TAILORED UNIFORMS

SnoWhite Garment Mfg. Co.,
946-948 N. 27th Street, Milwaukee, Wis.

Tell us more about the trend towards white.

Name

Address

City..... State.....

Hospital

Just like a sentinel



For seventeen long years our Uncle Sam stands guard over every patent. To anyone snooping about in an effort to steal one he promptly cries, "Hands off!" Just think, for seventeen years Uncle Sam gives his protection, but after that a patent becomes public property.

Do you know that many of the best known U.S.P. drugs of today were originally developed as specialties and protected by patent rights? Good drugs they are, too, and their value has been well proved. But, bear in mind, such drugs, representing in practically each case a scientific advance in their day, were available to the profession for seventeen years before they were admitted to the U. S. Pharmacopœia.

The Pharmacopœia is a blessing to the profession and to mankind. Of that there can be no doubt. But don't you think it is just a bit ridiculous to expound such a doctrine as "In your choice of medicinal agents confine yourself to U.S.P. and N.F. remedies"? Who wants to pass up a good remedy for seventeen years? Is it right for a hospital, in its desire to stint the pharmacy department by restricting it to U.S.P. and N.F. remedies, to be often seventeen years behind the times in treatment?

Don't stint your pharmacy department. Roche Medicines are well within the means of even curtailed budgets when brought direct from our Hospital Sales Department. Send for the Roche direct-to-hospital price list.

HOFFMANN-LA ROCHE, INC.

Nutley New Jersey



A Page of Letters to the Editor

A ROTARY CLUB TALK

Editor, HOSPITAL MANAGEMENT: I have been requested to speak before the Rotary Club on hospitals. Can you give me a brief history of the origin and progress of hospitals in this country?

Also, will you please supply me with references on any pertinent reading matter contained in HOSPITAL MANAGEMENT during the past five years, as I have a complete file of HOSPITAL MANAGEMENT covering that period? I recall one definite article which was entitled, "A Talk about Hospitals for your Rotary Club."

As the time is necessarily short, in which to prepare such a talk, I will appreciate any material you can send me. In your own opinion, what do you think should be carried to the public in which they would be most interested? It is my desire to tell this group what the hospital means to the community.

C. A. SHARKEY,
Superintendent Lakewood City
Hospital, Lakewood, Ohio.



COLLECTION LETTERS

Editor, HOSPITAL MANAGEMENT: Would you be good enough to send us reprints of your articles on collecting patients' bills, containing sample letters? Our renewal subscription will come to you in a few days.

HELEN MCBRIDE,
Superintendent, Princeton
Hospital, Princeton, N. J.



1932 AND 1931

Editor, HOSPITAL MANAGEMENT: It occurred to me that some of your readers might be interested in the following statistics taken from our records, which, if typical of other institutions, show very clearly the added burden which has been placed on hospitals by the economic situation.

Comparison of the services for the first six months of 1932 and 1931:

	1932	1931	Percentage of dec. and inc.
Private and semi-private patient days' care.....	10,897	12,161	10.4 dec.
Private and semi-private room payments.....	\$92,385.44	\$106,706.80	13.4 dec.
Ward patient days' care.....	19,140	17,084	12.0 inc.
Ward patient payments.....	\$33,408.95	\$35,875.76	7.0 dec.
Special nursing days.....	6,152	7,718	20.3 dec.
Out-patient visits	22,183	19,235	15.5 inc.

ABOUT AUTO ACCIDENTS

Editor, HOSPITAL MANAGEMENT: I read with the greatest interest your article in HOSPITAL MANAGEMENT entitled "How Some Hospital Groups Try to Solve Auto Problems." Evidently I have not brought to your attention a rather careful study which this department made during 1931 of losses suffered by hospitals in this State from non-paying accident patients who received care during 1930. This study was made at the suggestion of a member of the New York Assembly in order that we might be able to supply the legislature

Here are a few more letters to the editor which are reproduced for the information they contain or to reflect matters of current interest.

The editor cordially thanks those who have answered questions raised by letters in past issues and hopes that whenever such questions are asked, readers will feel free to correspond with the inquirers and to exchange information and comments.

"Hospital Management" at all times welcomes questions or comments on individual problems of hospital executives and will make a special effort to supply information or suggestions indicated.

with information as to the losses sustained by hospitals in this State to be used in connection with an amendment to the lien law which has been sponsored by this member. Our request for information was sent only to those hospitals which, from my knowledge of their work, I believed would be likely to have automobile accident cases. Without going into the details of the returns I can give this brief summary:

As to automobile accident cases, 76 hospitals with 7,108 beds supplied complete information. Their reports showed that during 1930 these hospitals cared for 7,198 automobile accident cases for a total of 77,196 days. Of these, 1,541 patients who had received 21,479 days of care did not pay their bills, entailing a loss to the hospital estimated by the superintendents as amounting to \$98,870.75.

With reference to accidents not involving automobiles and not coming within the Workmen's Compensation Law, 66

JAMES U. NORRIS,
Superintendent, Woman's Hospital,
New York.

hospitals with 6,213 beds reported that during 1930, 5,683 such accident cases received 60,925 days of care. Of these, 1,269 patients receiving 13,249 days of care did not pay their bills, entailing a loss to hospitals, estimated by the superintendents, as amounting to \$55,234.08.

Many hospitals replied saying that their losses from accident cases were negligible. I think it is fair to assume that the returns mentioned above include a very

large part of the losses to hospitals from automobile and other accident cases during 1930. I am, therefore, offering the following conclusions:

1. So far as New York State is concerned, the losses incurred by hospitals from automobile and other accident cases not coming within the Workmen's Compensation Law is less than has been indicated by certain studies and estimates made elsewhere when due consideration is given to the population of New York and the number of hospitals and hospital beds available. The total amount is, however, large, and both this department and the Hospital Association of New York State will doubtless continue in the efforts which we have been making from time to time for sixteen years to secure certain amendments to the lien law for the benefit of hospitals in respect to accident cases.

2. From letters received and observations made I conclude that hospitals are learning how to collect bills for accident cases and in certain localities are assisted by county and city public welfare officials who cooperate with the hospitals. Such cooperation might be extended further than is now customary.

CLARENCE E. FORD,
Assistant Commissioner, New York State
Department of Social Welfare, Albany.



COURSE IN ADMINISTRATION

Editor, HOSPITAL MANAGEMENT: I wonder if in your study of the courses in hospital administration you have never heard of the one that is being given at Teachers College this month. I am enclosing the copy of the course that was given during 1931, and I presume is being given this year. This course was also given last year as one of the regular courses.

ADDA ELDRIDGE,
Director, Bureau of Nursing Education,
State Board of Health, Madison, Wis.



WHAT DO YOU SAY?

Editor Hospital Management: I have received the following query from a member of the board of managers of one of the general hospitals in New Jersey:

"It has been the practice to charge bad debts as an expense, and I should like to know whether this is in accord with the general practice."

Won't you be good enough to let me know what has been the practice in hospitals?

EMIL FRANKEL, Ph. D.,
Director of Research,
Department Institutions and Agencies,
Trenton, N. J.



REPORTING SOCIAL SERVICE

Editor, HOSPITAL MANAGEMENT: Replying to your request in HOSPITAL MANAGEMENT for an explanation of the comparative length of annual reports of hospital and social service departments, I should like to offer my comments. I was interested in the statement that the depart-

ment of social work receives a large amount of space in the average annual hospital report. If this is a fact, I should think the explanation, if one is needed, should come from the superintendent, who is responsible for the publication of the report.

Theoretically, however, it seems to me there may be two general explanations for the length of the annual reports of the social service department. The first is found in the underlying purpose of an annual report of an institution such as a hospital which I believe endeavors to give its supporters, be they taxpayers or contributors of voluntary gifts, not only an accounting of the institution's activities during the year just closed, but also an interpretation given in such a way as to stimulate interest in continued support and approval of the program. Because the social service department in fulfilling its case work function, records and reports activities which frequently interpret effectively the hospital in its community service, a descriptive report of this department is valuable to the report.

Secondly, methods of statistical reporting in social work, especially in the field of medical social work, have not been standardized or sufficiently developed adequately to interpret the work of the department. Therefore, annual statistical reports are rare and the descriptive or narrative report has been thought necessary. The work which the United States Children's Bureau is doing in the field of medical social statistics will undoubtedly modify this practice to some extent.

I wonder whether you mean to imply that the importance or value of a department to a hospital can be measured by the length of its annual report. I feel sure you do not think so, yet the mere raising of the question leads one to believe that the implication has been made. This seems to be most unfortunate, as I believe each should fit into the whole program and contribute its proportionate share to the more effective care of the patient through the particular service it is equipped to give. Actually I think the question is relatively unimportant even in the 15 per cent of the hospitals of the country which have departments of social work.

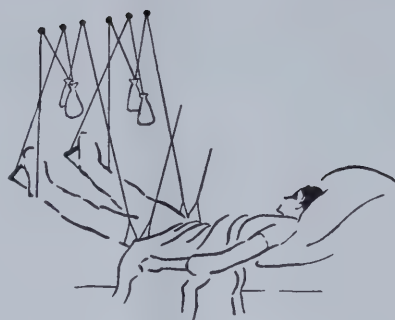
HELEN BECKLEY,
Executive Secretary, American Association
of Hospital Social Workers.

ANYBODY ELSE?

Editor, HOSPITAL MANAGEMENT: As one of the many who has been educated largely in the school of hard knocks and by popular "true and false" method, I am taking the liberty of recording my feeling with regard to your query in your April 15 number:

"What kind of training course does the field want?"

Others in the "too modest" class you mention do not seem to have responded; too sensitive to their deficiencies perhaps, just as I am. However, in this case and for the good of the cause, I am willing to bury my pride and, for my own protection, my name. As one of the "great group of men and women who know their limitations and are anxious to improve their knowledge and ability," I feel that the time is ripe for a university course and that a definite and determined effort should be made by our American Hospital Association to develop such a course in



one of our central university hospitals or medical centers. It cannot be done by an individual.

It is undoubtedly a difficult task, but until something concrete is accomplished, but very little response from the field can be expected. Whether or not a degree is given upon completion of the course, although highly desirable, is, to my mind, of minor importance, as compared with the advantages which will result from the theoretical and practical work in a large and well organized institution. For the benefit of those who are employed, I would suggest a series of short courses of from three to six months which would make it possible for most of us to take advantage of them. The period between courses could be devoted to texts and correspondence work. Where time and means permit, however, a straight one year's course would be better. There are men whose names are by-words in hospital activities and who give liberally of their time to us at conventions, etc., and I am sure these men would rise to the occasion and prove able, willing and impressive teachers.

The question of tuition fees and maintenance is one which will no doubt prove an obstacle to many, but given enough publicity, persistent and consistent, the interest of some of our philanthropists may be attracted and a scholarship fund obtained.

Meanwhile, we may obtain a great deal of benefit by reading and digesting the contents of our excellent hospital magazines and attending meetings and conventions. I, personally, make frequent requests for information from the fellow superintendents and find it a pleasure to answer any requests made to me for information.

X. Y. Z.

A. H. A. COURSE?

Editor, HOSPITAL MANAGEMENT: I understand that the American Hospital Association is planning to inaugurate a



course in hospital management around October 1 of this year, to be given in connection with various hospitals throughout the country.

I am wondering if you would be good enough to furnish me with any information regarding this course which you have available at this time, such as educational requirements, time required for completion, probable cost, and any other information which you might care to place in my hands.

It is my desire to take such a course whenever one is available.

W. TAFT HAUN,
Knoxville, Tenn.

PRESIDENT BECOMES SUPERINTENDENT

Editor, HOSPITAL MANAGEMENT: As a matter of economy, the board has told me they will put the president of the board in charge of the hospital, which will let me out. This is another case of the superintendent being replaced by the board to try to retrench. My record has been good. My auditor's report each year will show that the hospital made money each year, instead of running in the "red" as most business places are doing in these times. I went through some of the worst months.

For a long time I was afraid the hospital could not continue to stay open. If they save my salary it will give them that much to pay on bills. However, I am making a "sacrifice hit" to bring this over.

Keep me in mind if you hear of an opening. I will be willing to go in a hospital as the assistant, buyer, or cashier, etc. I have done maintenance and all sorts of things here. Later I could probably get another small hospital.

UNEMPLOYED.

FOR SMALL HOSPITALS

Editor, HOSPITAL MANAGEMENT: Can you supply me with, or tell me where I can get a list of small hospitals in the middle west which have no laboratory in connection with the hospital? I am just completing a six months' course in laboratory technique and because of the scarcity of openings at this time, I have been unable to get a position. I want to make contact with hospitals which might be interested in allowing me to establish a private laboratory in connection with the hospital on a commission basis. I can supply references as to the thoroughness of my training.

M. D.

HAPPY DAYS, ETC.

Editor, HOSPITAL MANAGEMENT: July was the only month this year that we failed to collect enough money to meet operating expenses and interest on debt. August is showing a decided improvement. We have the finest cotton and grain crops that West Texas has ever had and the prices are advancing. "Watch West Texas!"

E. M. COLLIER,
Superintendent, West Texas Baptist
Sanitarium, Abilene.

P. S.—Fourteen operations today. How's that for a 50-bed hospital?



The Smart Dessert

IT'S smart to be thrifty, say economists—both business and household variety. But there is more reason than just thrift for the appeal in Edelweiss Gelatine Desserts. They are so easily made, so inexpensive to prepare, so jewel-like in their consistency, that they will make more profit for you than many a fancy combination that is neither so attractive nor so edible.

"SEXTON'S MONTHLY SPECIALS"

brings regularly to the institutional market information on prices. It is replete with unusual values, special offers, timely suggestions. If you are not regularly receiving it, write for the current copy.

The opening of schools each year is reflected in increased business activity. Hotels and restaurants profit from the additional travel and from the greater number of shoppers in the business districts. Schools themselves are large buyers of foods. Sexton service to this important market is national in scope. Each year, a large number of schools come to John Sexton & Co. for their food requirements. This growing patronage is endorsement by trained buyers testifying to the full food value, delicious flavor and practical economy of Sexton products.

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THE HOSPITAL ROUND TABLE

Visiting Patients

"Should superintendents of hospitals of 100 beds or less visit patients daily?" was a question asked at a recent meeting. Discussion indicated that some felt that the superintendent should not be expected to do this, and that, as a matter of fact, visiting by the superintendent should be done only in exceptional cases where complaints or misunderstandings occur.

It was pointed out that some patients do not want to be visited and that many superintendents are not of the proper personality to make visits a success. On the other hand, some representatives of smaller hospitals felt that it was worth while for the superintendent to make personal contact with patients.

During the discussion one speaker said that a superintendent of a small hospital, a man, recently said that after checking over a series of patients on whom he had called frequently during their stay, he was convinced that many patients take advantage of the friendship developed by visits to "kick" about things and also to task financial concessions or to obtain delay in paying their bills.

Some Per Capita Costs

Per capita costs reported by hospitals in their annual reports for 1931 include:

St. Luke's Hospital, New Bedford, Mass., 83,663 patient days, \$4.62, decrease of 10.6 cents per patient day compared with 1930.

Homeopathic Hospital, East Orange, N. J., 29,229 patient days, \$6.22, decrease of three cents compared with 1930.

Episcopal Hospital, Philadelphia, 293 patients daily, \$3.78 for ward patients, compared with \$4.17 for 1930; \$7.88 and \$7.08 for private patients.

Woman's Hospital, New York, 73,674 patient days, \$8.24 for private patients, \$5.73, ward patients. 1930 costs, private patients, \$8.20; ward patients, \$6.50.

Muhlenberg Hospital, Plainfield, N. J., average 183 patients, \$4.48. In 1930 the patient day cost was \$4.85.

Grace Hospital, New Haven, Conn., 71,736 patient days, per diem

per patient operating cost, \$5.85. In 1930 this cost was \$6.06.

New York Post-Graduate Hospital, New York, 103,685 patient days; daily average cost, all patients, \$7.97. In 1930 this cost was \$8.26.

Jewish Hospital, Philadelphia, 102,109 patient days, \$4.27, a decrease of 28 cents compared with 1930.

Christ Hospital, Cincinnati, 68,117 patient days, \$7.95.

Hospital Certificates

Highland Park Hospital, Highland Park, Ill., recently began a drive to sell hospital certificates, good for hospital service to the amount subscribed. A number of handicaps interfered with the effort, such as a sudden out of town business engagement of the executive in charge of the campaign, some of Chicago's record breaking heat, etc. Despite these obstacles the campaign succeeded to a certain extent, according to Miss Ibsen, superintendent, and others actively interested. Although the amount subscribed did not reach expectations, a fair sum was realized, and it was felt that the contacts made were valuable for the hospital. The campaign is to be resumed in the fall. Some of the advantages of a campaign of this kind is that it is not a charity drive, for subscribers receive service up to the amount subscribed, subject to the conditions of the drive, and some donors are led to take an active interest in the institution. A number of the subscribers, of course, will not require hospital care during the time the certificate is effective.

Employees' Ideas

Many business organizations have found that the executive and supervisory staff is not the only source of ideas of value to the company says an announcement of the Metropolitan Life Insurance Company. The close contacts of the workers with particular operations of the business frequently enables them to supply ideas and suggestions of direct benefit to the company. To capitalize upon this practical experience and specialized knowledge, the employe suggestion system has been adopted with considerable success by a number of organizations. Through some form of organized suggestion plan, workers are encouraged to look for possible

improvements in the operation of the business to present their ideas so that, if practicable, they may be adopted by the management.

"Employees' Suggestion Systems," a new report published by the Policyholders Service Bureau of the Metropolitan Life Insurance Company, discusses the methods used by representative industrial companies to obtain worthwhile suggestions from their personnel. The report is based on a study of the systems of more than 100 organizations, and describes the outstanding features of these plans.

Referring to the benefits of employees' suggestions, the study states that "they have been found to result in savings in operating costs, increased production, extension of business, improved operating methods, and better working conditions." The effect which the actual adoption of satisfactory suggestions has upon the general morale of workers, in tending to make the latter realize that they are holding a recognized place in the business, is considered of more than ordinary importance by a number of organizations. In addition, it is believed that formal suggestion plans, by encouraging employees to think, provide an excellent groundwork for training.

A limited number of copies of "Employees' Suggestion Systems" are available for general distribution.

Loaning Property

"I note your request in HOSPITAL MANAGEMENT," wrote Charles H. Dabbs, superintendent, Tuomey Hospital, Sumter, S. C., to Mrs. M. Howard, business manager, Boothray Memorial Hospital, Goodland, Kan., who asked for suggestions as to charges to be made for the loan of apparatus to a patient. "Our custom is to make a charge for any hospital property taken out for use at home. We likewise charge a deposit to insure its return. Both charge and deposit depend upon the value of the equipment and likelihood for wear, damage and breakage. On glassware we charge one-half value, enamel ware one-third, electric pump 50 cents a day, wheel chairs \$5 a week, fracture beds \$10 per month, fracture apparatus or splints according to the chart of recommended deposit and charge as furnished by the manufacture."

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HOSPITAL MANAGEMENT

A Practical Journal of Administration



Meeting Today's Conditions Is Universal Problem

Financial Situation of Hospitals Is Constantly Recurring Topic at A. H. A. Convention; Hospital Insurance Gets Widespread Consideration

By MATTHEW O. FOLEY

CONSTANTLY recurring throughout one of the friendliest and most enjoyable conventions of the American Hospital Association at Detroit, September 12-16, was a discussion of efforts of the hospitals to meet present economic conditions. The program contained many formal reports and discussions of this general topic, but the universal interest in economic problems also was reflected in the practically ceaseless mention of financial difficulties in the informal conversations in hotel lobbies, exposition hall, dining rooms, and wherever even two visitors met.

Everybody was looking for new methods of reducing expense and of some further suggestions as to how operating revenue might be increased. Few suggestions of a completely new type were offered, but there were variations of accepted ideas that were eagerly seized on.

Some of the ideas mentioned which were supplemented with statements that they had met with success in individual instances were:

Operation of a small canning factory by a southern hospital which accepted farm products in lieu of cash for service to patients. This hospital, in a rural area, also accepted livestock, such as cattle, and in this way has managed to finance a great deal of service which would not have been paid for had cash been insisted on.

Papers and round tables dealing with economic problems or offering the slightest opportunity to ask questions about ways of economizing or of increasing income were by far the most popular at the Detroit convention. Hospital insurance, for instance, provoked such interest that a group met after the regular program and later engaged a table at the banquet in order to go into details as much as possible. It is likely that efforts to establish insurance schemes for the purpose of paying for hospital service will be made in many communities as a result of the experiences and plans related at Detroit.

A topic of special interest at the convention was the matter of community or public hospital insurance—that is, insurance by which individuals on the payment of a small annual fee would be assured of hospital service over a definite period and subject to definite conditions. A round table on this topic not only overran the allotted time, but resulted in a sort of an adjourned discussion after the chairman had formally closed the program. This round table developed experiences of several types of this insurance already in effect. The newest development

in this line, however, was the banding together of a group of hospitals in such a plan in order to permit a subscriber to select any hospital in the community. Another great advantage of this plan was that it has the wholehearted and enthusiastic support of the physicians, who feel that since a small annual fee under the insurance plan will take care of the hospital bill, there is much more likelihood of payment of the professional fee. Moreover, with leading hospitals of the community joining in the plan, the majority of physicians will benefit as well as the patient.

One of the variations of salary reductions which was offered as especially helpful in encouraging cooperation of personnel in the conservation of supplies and in general operating economy was the tentative cut. One hospital has put such a plan into effect, telling employees that it will deduct a certain percentage of salary each month, but that this sum will be repaid at the end of the fiscal year in proportion to the closeness with which the hospital lives up to its budget. According to one superintendent who spoke of this plan, the first eight months of the year indicated that the reduction would be only about 50 per cent of what had been announced in the beginning of the year. In other words, certain employees had been told that they were to be cut 10 per cent, but the

Increasing Revenue and Cutting Expense

Some of the things hospitals are doing to meet present conditions, as indicated by comment at the 1932 A. H. A. convention:

Use of the insurance idea in meeting cost of hospital service, was a topic that frequently was mentioned and a number of plans were described.

Contract with authorities for hospital service during Citizens' Military Training Camp and national guard encampment.

Brief summaries of individual cases of free and part-free work, sent to wealthy citizens, have produced substantial contributions to the hospital.

Flat rates, based on advance payment; discounts for full payment on discharge.

Acceptance of farm products and live stock in return for hospital service. Canning factory operated by hospital to can produce accepted.

Revision of courtesy discount lists; elimination from discounts of extra charges, leaving discount applicable only to room rates.

General expression of the value of courtesy and diplomacy in handling patients and visitors, and a desire to serve willingly; use of local newspaper articles, talks, etc.

Some hospitals insisted that rate reductions did not increase occupancy and made readjustment upward at a

later date difficult; others were positive that occupancy was increased by reduction of rates.

Tentative salary reductions have been made, based on showing of hospital in regard to budget limitations at end of fiscal year.

One hospital, in an unusually favorable position to do so, sells solutions not obtainable in drug stores, and rents special apparatus and equipment to physicians and patients, reporting nearly \$50 a day average revenue since this practice was begun a year ago.

Central dressing and supply rooms were offered as an exceptionally practical economy.

Use of a new type of improved fluoroscope was described as increasing certain types of work in the hospital, and productive of favorable publicity which resulted in the receipt of a donation covering the cost of the apparatus.

Use of senior students to replace supervisors on vacation.

Some hospitals permit graduate nurses to occupy rooms in a part of the hospital building, at a nominal fee.

Establishment of charges to physicians and personnel for meals in the hospital dining room, these people previously having received free meals. This is credited with materially reducing the number of complaints regarding menus, etc.

hospital had made such a good showing, relatively, that the cut had been or would be reduced to 5 per cent of the salary, provided the same record could be maintained till the end of the year.

One new source of income which may be open to hospitals in different states near Citizen Military Training Camps and national guard encampments was reported by an institution which has a contract with the war department and with the state for furnishing hospital service during these camp periods. The income represented a worth while sum and the work was done during the summer period when ordinary demands on the hospital were light.

The practical value of a rate reduction received much consideration. One showing of hands indicated that a slight majority felt that rate-cutting had increased demands for service, but the number was only slightly more than those who asserted that rate-cutting did not help. Those opposing reduction of charges pointed out that most hospitals had rates from "nothing up," anyway, and if a person could not afford a room at a certain price, other accommodations at less cost were available. It also was pointed out that if reduc-

tions were made generally, it would be difficult to re-establish original charges, which in many instances were lower than they should be.

Seven hospitals in one group indicated that they had not made any reduction in charges, urging that no reduction was advisable. Some points offered in explanation of this stand were:

Lower rates do not increase illness nor occasion the use of hospital.

The hospital now has rooms and accommodations at different rates, and if a patient does not want to pay for a certain room, other accommodations in the desired price range are available.

The reduction of rates may be interpreted by the public as a confession that previous rates were profit-producing.

Another hospital which did not reduce rates reported that its occupancy and use of certain departments was greater than the same departments in another hospital which had reduced rates.

Throughout discussions of ways and means of increasing revenue there was the suggestion that good service was the most important consideration. Smiling, tactful, sympathetic and willing personnel were

mentioned as really important and practical aids in increasing occupancy and in "advertising" the hospital by word of mouth, which, as every one agrees, is the very finest kind of public education and the best source of sympathetic interest and support. The practical use of such means as bulletins and pamphlets, newspaper articles, talks before clubs and similar ideas was urged, and few sessions there were that did not see some reference to the importance of a program of community relations.

In the line of "telling the public" as a means of encouraging assistance in meeting the cost of free and part-free service, one superintendent reported a unique plan of preparing a very brief summary of instances of cases of charity work. A number of these summaries were written on a sheet of paper in mimeograph form and sent to a selected list of influential and wealthy citizens. Splendid responses in the form of donations were reported, the latest contribution from one wealthy woman being given as \$1,000.

Flat rates were reported by an increased number of hospitals and some unique rates were mentioned, including rates for three days in the maternity ward. This short period was offered to patients who otherwise could not be persuaded to come to the hospital, and in one instance, it was reported that physicians had agreed to make a reduction in their fees to patients who would come to the hospital for even this brief stay, as hospital conveniences and services were thus highly appreciated by the attending physician. When patients remained longer, various arrangements applied as to daily rate.

Another development resulting from present conditions was the very careful scrutiny of courtesy discounts. In some instances where these discounts had applied to extras as well as rooms, the rooms only were included, and the extras charged for at regular rates. Many hospitals, moreover, reduced their discount schedule and in some instances removed certain groups which had previously been entitled to discount but whose individual members in many instances commanded good salaries. Of course, as formerly, every application for reduced charges is to be considered on its merits.

One unusually progressive hospital, of more than average capacity, reported the sale of solutions and the rental of special equipment to physicians. These materials and supplies are handled in the central dressing and supply room of the hospital. The idea for renting equipment to

physicians came from occasional requests for the loan of such equipment, which was of such a character as to be infrequently used by an individual doctor and so expensive as not to justify its purchase by a doctor. A nominal rental fee, however, now insures that the physician may have this equipment, in perfect condition and ready for instant use, any time he may have occasion to use it in the home of a patient, etc. In the same way, the hospital now regularly sells solutions and similar preparations which are not available in drug stores. In this hospital, the sale of such supplies and the rental of equipment runs up to around \$50 a day. The superintendent who is in charge of the hospital said he was certain that many other hospitals could use such a plan.

Another means of increasing cash payment which was reported by several hospitals was the offer of a 10 per cent reduction on a flat rate provided the bill was paid on admission. A variation was to offer a discount of 50 cents a day off bills which were paid on discharge.

Another hospital eliminated charges for laboratory and delivery room to maternity patients paying in advance.

Along the general lines of methods of reducing expenses, one superintendent asserted that he was many times repaid for coming to Detroit because he had learned that his hospital is exempt from taxes on gas and electricity. This exemption, which is provided under the law taxing consumers of electricity and gas, applies to non-commercial users, and while this superintendent had heard that hospitals were exempt, he had not followed the matter up. After hearing from a number of other hospitals about the exemption, however, he is going to have the tax paid by the hospital since the law became effective returned.

Cooperation of county and municipal authorities in the matter of reimbursing hospitals for service to indigents was a subject of much discussion, and a number of hospitals reported obtaining this cooperation in the form of a more adequate rate. The Essex County Hospital Council, Newark, N. J., announced that hospitals of Newark were to be paid a rate of \$4 a day for indigents by the city.

AT LAKE VIEW

A. E. Abernathy has been appointed superintendent of Lake View Hospital, Chicago, succeeding J. Dewey Lutes, who resigned some time ago to assume charge of Ravenswood Hospital in the same city.

Hospital Cooperation Urged In Insurance Plans

Watch for a most interesting and practical article on hospital insurance plans in an early issue. Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., who conducted the A.H.A. discussion of this subject and who has made a detailed study of various plans, is the author. Mr. Jolly has begun an insurance project which he believes embodies all the good points of different schemes and this will be described. Readers desiring information about insurance plans should write to "Hospital Management."

THE cooperation of a group of hospitals in a community in working out an insurance plan for the payment of hospital bills was urged by several speakers during discussions of this topic at the A. H. A. convention. Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., who has signed a contract for the operation of such a plan, asserts that the group idea is preferable to the plan of having each hospital handle the insurance individually. In the Houston plan, five hospitals are cooperating.

Advantages of the insurance plan by a group of hospitals as cited by Mr. Jolly are:

With a number of hospitals cooperating, the patient will have a choice of hospitals, and thus the family physician's hospital is more likely to be included among the choices offered. Under the single hospital plan, of course, all physicians not on the staff of that hospital may oppose the scheme, since they could not treat their patients in a hospital of whose staff they were not a member.

Besides obtaining the cooperation and support of more physicians, an insurance plan such as contemplated gives the doctor a better chance to obtain his fee, since the hospital bill can be covered by the annual payment. For instance, instead of a \$90 hospital bill, the patient with the insurance protection pays only his annual membership. This advantage applies to both single hospital and group hospital plans.

With several hospitals cooperating, greater effort and intensity may be

put into the sales and other features of the plan.

Another supporter of the group hospital insurance plan is the Essex County Hospital Council, Newark, N. J., Frank Van Dyk, executive secretary. This council is perfecting final details of an insurance plan in which six hospitals will cooperate.

San Antonio was mentioned as a city in which a group of hospitals have been cooperating with satisfaction for more than a year. Mr. Jolly reported that the Houston hospitals are interested in a modified San Antonio plan.

Adherents of the individual hospital insurance plan, however, believe that their plan is the only feasible one in communities in which cooperation among hospitals cannot be developed. This state of affairs makes it impossible for a group hospital plan to be projected, and rather than pass up the advantages of hospital insurance as they see it, in a number of instances individual hospitals are going ahead along lines developed by Baylor Hospital, Dallas, Tex., or other institutions.

There are two varieties of individual hospital insurance plans. One puts the entire matter in the hands of the hospital, which sells the contracts, makes the collections from members, etc. The other plan utilizes a sales organization for selling the memberships, the salesmen receiving a commission. Details of the type of service, length of stay in the hospital, and other conditions vary in each city, and, as noted, there is a variation in the contracts as the plan spreads, each new hospital or group revising the conditions to make the plan more satisfactory, in their opinion.

It is the plan of the Houston group, which includes, besides Memorial Hospital, the Methodist Hospital, Ear, Nose and Throat Hospital, the Houston Heights Hospital and Parkview, to give members of the insurance scheme a \$5 room for a period up to 18 days for the \$9 membership. Routine laboratory and a \$10 operating room fee also are included. For the present only people who are employed will be admitted to the insurance plan, the theory being that such people may ordinarily be expected to be in good health. Further details regarding this and other plans will be described in an article by Mr. Jolly in a later issue.

The New Golf "Champ"—Dr. MacEachern's "Taxi"—A Surprise Flight—And Other Inter- esting Happenings at the A. H. A. Convention

There was no opposition to the recommendations of the nominating committee, which follow:

President-elect, Dr. N. W. Faxon, Strong Memorial Hospital, Rochester, N. Y.

First vice-president, Dr. B. W. Black, Highland Hospital, Oakland, Calif.

Second vice-president, Dr. Stewart Hamilton, Harper Hospital, Detroit.

Third vice-president, Miss Lake Johnson, Good Samaritan Hospital, Lexington, Ky.

Treasurer, Asa S. Bacon, Presbyterian Hospital, Chicago.

Trustees (three years): Dr. Winford H. Smith, Johns Hopkins Hospital, Baltimore; Carolyn E. Davis, Good Samaritan Hospital, Portland, Ore.

Trustee (to fill unexpired term of Dr. Faxon), Paul H. Fesler, Wesley Memorial Hospital, Chicago.

* * *

"Hospitals must adopt a plan of education. They must utilize every means of disseminating information about themselves." This was one of the points emphasized in the practical and comprehensive report of the committee on public relations. "This report ought to answer for all time the question of the A. H. A. stand on publicity for hospitals," said one visitor, "for it not only says it is ethical and desirable, but that publicity is necessary." Hospital pamphlets and bulletins and use of newspaper articles were among features of public education discussed at length.

* * *

An increasing use of hospitals reported the successful use of the local newspaper articles which are offered the field for weekly publication by HOSPITAL MANAGEMENT. Reports of their use came from California to the Carolinas and from the central south to upper Minnesota.

* * *

Among those who bore new titles since the last convention were Dr. A. J. McRae, new superintendent of Meadowbrook Hospital, Hampstead,

L. I., and Dr. C. D. Frost, new superintendent of Union Memorial Hospital, Baltimore.

* * *

Edgar C. Hayhow, superintendent of Paterson General Hospital, Paterson, N. J., whose institution won the 1932 National Hospital award of the A. H. A., was among the many who flew to Detroit. One of the most interested plane passengers, however, was Mrs. John M. Smith, whose husband secretly arranged all details of her flight and did not tell her she was to go by air until he gave her the plane ticket. "And, although you could have knocked me over with a feather when he told me," said Mrs. Smith, in telling of the incident later, "I very calmly said, 'Oh, isn't that lovely.'"

* * *

Paterson General Hospital now

The new champion of hospital golfers is none other than Dr. Fred G. Carter, Ancker Hospital, St. Paul, Minn., who rented a set of clubs and played the course in his street clothes, yet led the field with the very good score of 91, gross. With a handicap of 17 Dr. Carter netted a 74, thus giving him possession of the very handsome trophy Toronto hospital administrators put up for the annual contest. Dr. Carter's victory was a great relief to Louis J. McKenney, trustee, Highland Park Hospital, chairman of the golf committee, for had not the St. Paul phenom come through so handsomely Mr. McKenney would have been in the embarrassing position of having to present the cup to himself. Mr. McKenney showed he was just as good a golfer as he was a chairman for the trustees' section, by turning in a net of 75. H. J. Harwick and Roy Watson helped to set the pace for the new champion.

joins this group of National Hospital Day award winners:

1931—Brantford General Hospital, Brantford, Ont.

1930—Richmond Memorial Hospital, Prince Bay, N. Y.

1929—Bergen Pines, Ridgewood, N. J.

1928—Bushwick Hospital, Brooklyn.

1927—John D. Archbold Memorial Hospital, Thomasville, Ga.

1926—Veterans Hospital, Waukesha, Wis.

1925—Pottstown Hospital, Pottstown, Pa.

* * *

The democracy of the American Hospital Association was typified Thursday night when President-elect George Stephens and the next president-elect, Dr. N. W. Faxon, were noted in the hotel cafeteria, nonchalantly carrying their dinner on trays. They had attended a trustees' meeting and were getting a bite to eat before the night program.

* * *

One of the most interested visitors to the exposition in convention hall was Charlotte A. Aikens, who fought for the "commercial exhibit" in the early days, when this idea was severely frowned on by important people who thought that the exhibits would commercialize the association. One of the most active opponents of Miss Aikens' plan, who met her at the convention this year, admitted that there was some merit to the idea, after all. Miss Aikens had not seen the "commercial exhibit" in many years and was amazed at the growth and transformation that have taken place.

* * *

To the many honors and distinctions that have been earned by Paul H. Fesler, retiring president, now must be added inclusion in "Who's Who." He and Mayor Cermak of Chicago made this famous volume this year.

* * *

"By far the most interesting and most practical program we ever had" was the verdict of a number of vet-



Senator Copeland and Eddie Guest were speakers at the annual banquet, at which more than 800 were present.

eran administrators who attended the children's hospital sessions at Children's Hospital and the crippled children's school. These visitors suggested that Miss Rogers arise and take a bow.

* * *

Old timers recall that Dr. Goldwater, who prepared the report of the committee on plan and scope, was chairman of a similar committee way back in 1906. At that time he recommended committees on economics of hospital administration, medical organization and education, and on nursing. This year Chairman Goldwater recommended a council on medical economics, a council on hospital accounting, a council on nursing, a council on hospital medical practice and a council on community relations.

* * *

Dr. W. L. Quennell, Highland Park Hospital, was one of the most disappointed people in the world during convention week, owing to the fact that he was too ill to attend the sessions. He did manage to visit the convention hall Thursday afternoon for a little while and met many of his friends which helped to compensate for his enforced absence from the affair on which he had worked for so long.

* * *

W. Hamilton Crawford, South Mississippi Infirmary, Hattiesburg, was named chairman of the small hospital section. Dietitians chose Miss Harrington of Harper Hospital as chairman and Miss McLaughlin, University of Michigan Hospital, as secretary of their section. George D.

Sheats, Baptist Hospital, Memphis, was elected chairman of the Administration Section.

* * *

A few problems may have been solved at the convention, but one unanswered question was whether H.

Certificate of Award:

Paterson General Hospital, Paterson, N. J., Edgar C. Hayhow, superintendent.

Special Mention:

City Hospital, Louisville, Ky., J. Ernest Shouse, superintendent.
Manchester Memorial Hospital, South Manchester, Conn., Jane Aldrich, superintendent.

Honorable Mention:

Touro Infirmary, New Orleans, La.
Boulder-Colorado Sanitarium and Hospital, Boulder.
Philippine General Hospital, Manila.
South Mississippi Infirmary, Hattiesburg.
Veterans Administration Hospital, American Lake, Wash.
Ex-Patients' Tubercular Home, Denver.
Mt. Sinai Hospital, Hartford, Conn.
Ball Memorial Hospital, Muncie, Ind.
New England Sanitarium and Hospital, Melrose, Mass.
Public General Hospital, Chatham, Ont.
Baptist Hospital, Little Rock, Ark.

The foregoing announcement was made on behalf of C. J. Cummings, Tacoma General Hospital, Tacoma, Wash., at the President's Night meeting, when Mr. Hayhow received the award for the best National Hospital Day program.

J. Southmayd, Commonwealth Fund, or Father Griffin was the more economical in strokes in their golf round.

* * *

"A big man for a big job," said somebody when Dr. Thomas K. Gruber, superintendent, Wayne County institutions, Eloise, Mich., was introduced to the Protestant Hospital Association by the Rev. Mr. Haag as a man in charge of probably the largest institution represented at the conventions. Dr. Gruber said that that day the population of the Eloise group was 7,807.

* * *

Among those attending the conference of state and sectional officers, and American Hospital Association trustees, were Mr. Fesler, Mr. Borden, Mr. Bacon, Father Griffin, Dr. Olsen, Mr. Bates, Miss Davis, Dr. Stephens, Dr. Washburn, Dr. W. H. Smith, Mr. Wolf, Dr. Thompson, Mr. Rowlands, Miss Brandt, Indiana; Mr. Fingerhood, New York; Mr. Wickenden, United Hospital Fund; Dr. Goldwater, Dr. MacEachern; Mr. Burt, Georgia; Rev. Mr. Martin, Mr. Dwyer, New Jersey; Dr. Mason, Dr. Sexton, Mr. Bartine, Connecticut; Mr. Norby, nursing committee; Mr. McNee, Minnesota; Mr. Howe, Workmen's Compensation Committee; Miss Allen, New England; Miss Jamieson, Mr. Manix, Mr. Clark, Mr. Dodge, Ohio; Mr. McNary, Mr. Walter, Colorado; Mr. C. F. Smith, Iowa; Mr. McGinty, Mr. Gammill, Monsignor Fisher, Arkansas; Dr. Parnall, New York; Dr. Wood, New England; Mr. Sheats, Tennessee; Miss O'Roke, Ken-

"I take great pleasure in letting you all in on a secret," announced President Fesler on President's Night. "The trustees of the American Hospital Association have unanimously voted to present Matthew O. Foley, editorial director of 'Hospital Management,' with an engraved certificate in recognition of the fact that he originated National Hospital Day."

tucky; Miss McElderry, Alabama; Dr. Burlingham, Missouri; Mr. Wordell, Chicago; Mr. Crawford, Mississippi; Dr. Agnew, Dr. Hewitt, Canada; Mr. J. M. Smith, Pennsylvania; Mr. Calvin, Minnesota; Mr. Lutes, Illinois; Dr. Buerki, Wisconsin; Mrs. Armstrong, Western.

* * *

Dr. Faxon seconded an informal motion made during a casual conversation that the 1932-33 slogan of the American Hospital Association be "Let George do it!" Dr. Stephens, however, wants the usual amount of cooperation that a president must have.

* * *

The best report on hospital "business" came from a Maine superintendent, who said occupancy was up 32 per cent. A number of hospitals, however, said they operate without a loss. A general spirit of optimism prevailed as to the future.

* * *

The lowest cost for raw food per meal mentioned was nine cents. Several hospitals reported 10 cents.

* * *

Albert G. Hahn, business manager, Deaconess Hospital, Evansville, and Mrs. Hahn got great enjoyment out of a post card from Jack, 10 years old, who scrawled: "Guess the news! Guess the news! I'm in the band!"

* * *

Mexican visitors were Dr. F. L. Rocha and Dr. Serapio Muriara of Monterey, who represented the state of Nueva Leon, which is building a 500-bed hospital in Monterey.

* * *

Who can beat the record of S. Chester Fazio, superintendent, Rockaway Beach Hospital, Rockaway Beach, N. Y., who has rounded out 25 years in hospital service, although only 39 years old?

* * *

The headquarters staff of the A. H. A., not excepting Dr. Caldwell, managed the numerous and difficult details of the convention with their usual energy and perpetual willing-

Mr. Pitcher Named President-Elect of Protestant Group

CHARLES S. PITCHER, superintendent, Presbyterian Hospital, Philadelphia, whose experience in hospital administration covers more than 40 years in public and private hospitals, was elected president-elect of the Protestant Hospital Association at its annual meeting in Detroit. Mr. Pitcher's choice was unanimous and was regarded by his friends as a tribute to the long and faithful service he has rendered on various committees and in other activities.

Mr. Pitcher will assume office after the 1933 convention, which will be presided over by the Rev. Thomas A. Hyde, superintendent, Christ Hospital, Jersey City. Mr. Hyde assumed the presidency at the end of the 1932 program when the Rev. A. O. Fonksalsrud, Ph.D., concluded one of the most practical conferences in the history of the group.

New officers who will carry on with Mr. Hyde include:

Vice-president, John H. Olsen, Richmond Memorial Hospital, Prince Bay, N. Y.

Treasurer, Albert G. Hahn, Deaconess Hospital, Evansville, Ind.

Trustees: Dr. C. S. Woods, St. Luke's Hospital, Cleveland; Robert Jolly, Memorial Hospital, Houston; Rev. J. A. Bauernfiend, Evangelical Deaconess Hospital, Chicago; Dr. Fonksalsrud.

The executive committee immediately appointed Rev. F. C. English, executive secretary.

Special attention was given to informal and practical discussions of fundamental problems, and the round tables offered numerous opportunities for questions and for presentations of individual problems. The program was followed practically to the letter

ness and courtesy. Veteran visitors to the A. H. A. conventions will match them against the convention team of any organization.

* * *

The Canadian Hospital Council sponsored a delightful luncheon which it is hoped will be the forerunner of many similar events. It was the opinion of those present that the Council should arrange for a Canadian hospital conference. Dr. Routley and Dr. Agnew were active in arranging for the luncheon.

* * *

Indiana, Michigan, Tennessee, Ar-



CHARLES S. PITCHER

as presented in the last issue of HOSPITAL MANAGEMENT.

An innovation was the special service in the Episcopal Cathedral, at which the sermon was preached by the Rev. Mr. Hyde. It is planned to continue this feature each year, with special services in the church of the denomination of the president-elect.

The report of the resolution committee urged hospitals to co-operate with all movements having to do with the education of the public concerning hospital matters.

The attendance was most satisfactory in view of current conditions and was representative of many sections. This was forcibly demonstrated at the annual banquet where the happy custom of introducing those at each table by a selected spokesman was followed.

Kansas, Mississippi, Georgia, Illinois, Wisconsin, New York, Iowa, Minnesota, Ohio were among groups that had breakfast or lunch, either singly or jointly with neighboring states. Illinois, Indiana and Wisconsin have tentatively agreed on Chicago and the latter week in April as the place and time for 1933.

* * *

Despite the fact that he ought to be fairly well known at the convention, the man who presided on President's Night and at the annual banquet, as well as on other important occasions, was registered in the daily bulletin as

Dr. M. T. MacEachern, busy and preoccupied as ever, rushed out of his hotel one noon, and without watching closely stepped into a car. "Drive to the convention hall as fast as you can," he said, then he noticed that the car seemed luxuriously fitted for a taxi. Further scrutiny showed that the "doorman" was a private chauffeur, and then it dawned on Dr. MacEachern that he had jumped into the private car of one of Detroit's leading automobile manufacturers. Dr. MacEachern was a little more careful in examining taxicabs after that.

"Paul Fiske," Wesley Memorial Hospital.

* * *

Rumors are to the effect that Milwaukee will be hosts in 1933. It is less than two hours from the World's Fair.

* * *

Numerous requests for Mrs. Rhynas' paper on women's auxiliaries were reported by John H. Olsen, Richmond Memorial Hospital, Prince Bay, who presided at the small hospital section where this was read.

* * *

The attendance was a pleasant surprise to some pessimists and more than met the expectations of veteran members. Registration was officially reported as representing some 800 hospitals.

* * *

Detroit and Michigan hospital people did themselves proud in the local arrangements. The night meetings which were supervised by the local people were among the very best in the history of the association in point of attendance and excellence.

* * *

The usual "political" activity was in the background. A number of friends of Miss Davis, Dr. Munger and Mrs. Jolly mentioned their names occasionally, but when Dr. Babcock announced the recommendations of the nominating committee these were accepted without change.

* * *

Rev. H. L. Fritschel, Milwaukee Hospital, characterized the chronic patient as "the forgotten man" of the hospital field.

* * *

President Hoover wrote to President Fesler: "I will be obliged if you will express my cordial greetings to the convention of the American Hos-

Record Librarians Have Enjoyable Program at Detroit

RECORD librarians held one of their most enjoyable and beneficial programs at Detroit, September 12-16, and this first joint conference with the American Hospital Association is expected to be followed in the future, the group probably alternating with the American College of Surgeons, under whose sponsorship the thriving record librarians' association was established.

Besides the enjoyable and practical discussions and reports that featured the daily sessions of the record librarians, which were held in one of the meeting places of the American Hospital Association convention hall, the visitors had a most attractive exhibition, not only of association activities, but of material dealing with technical phases of the operation of the record department.

Balloting resulted as follows: President-elect, Miss Vredenburg, Woman's Hospital, New York; vice-presidents, Miss Hill, California Hospital, Los Angeles, and Miss Chase, Massachusetts General Hospital, Boston; corresponding secretary, Miss Gray, Memphis; recording secretary, Miss Boulton, St. Louis; treasurer, Miss Haag, Houston; councillors, three years, Sister Dominica, Cleveland, and Mrs. Wilson; one year, Miss Erickson, Akron.

The program was carried out practically as given in the last issue of HOSPITAL MANAGEMENT.

Numerous social and recreational activities were provided by the local committee. An innovation that promises to make the development of the association even more rapid than in recent years, was an informal conference of local and state chapter officers.

The annual banquet again proved to be a most enjoyable event, the guests responding to the magnetic personality of Mr. Jolly, and joining whole-heartedly in the fine tributes that were paid to Mrs. Grace W. Myers, honorary president and "mother" of the association.

Members voted the convention a most successful and profitable one, and heaped congratulations and praise on the officers and committees, especially Miss Wheelock, Mrs. Williams, Miss Pritchard, who were in charge of arrangements, program and exhibits. Maurine S. Wilson, Ravenswood Hospital, Chicago, presided at the different sessions, assisted by Mrs. Harned, Miss Kirkland, Miss Cavanaugh. Miss Kirkland, record librarian, Samuel Merritt Hospital, Oakland, succeeded to the presidency at the conclusion of the convention.

pital Association, and my deep sense of the value of the work of the hospitals both as centers of service based on the most modern advances of medical science and as centers of a great

spiritual impulse based upon the humanitarian instincts of our people, expressed in their financial and moral support." Mr. Hoover expressed similar sentiments to President Fonnalsrud of the Protestant Association.



N. W. FAXON, M. D.,
President-elect, American Hospital Association

EXHIBITORS' MEETING

The annual dinner and business meeting of the Hospital Exhibitors' Association was held at the Hotel Statler on the evening of Thursday during convention week, and was followed by a dance at which a number of hospital people were guests of the exhibitors. President F. L. Marvin introduced among other distinguished guests President Paul Fesler of the American Hospital Association, Dr. Bert Caldwell, executive secretary, and Father Griffin of the Catholic Hospital Association. Balloting for two new members of the Executive Board was next in order, and the election resulted in the selection of Mr. Marvin and F. J. Wilson to fill the vacancies. The board later chose Wallace M. Morton, of the Simmons Company, as president, and L. R. Eldridge, of Ad. Seidel Company, as secretary. Mr. Marvin was presented with a handsome wrist watch by Former President Thomas Rudisill on behalf of the organization, in recognition of his fine work during the year.

Huge New York Hospital-Cornell Medical Center Opened

Institution Will Have Daily Population of 3,000; 11 Buildings in Unit, Including 27-Story Main Hospital Block With Divisions for Private Patients, for Ward Patients, and for Employees' Quarters

The Association's building group takes in the three square blocks along the East River between 68th and 71st Streets, York Avenue and Exterior Street. Located just north of the site of the Rockefeller Institute for Medical Research, it forms, with the Institute, one of the most extensive groupings of medical institutions in the world. Some idea of the scope of the activities to be carried on at the center is indicated by the fact that the project has behind it the combined resources not only of the New York Hospital and Cornell University Medical College, but also those of the Lying-In Hospital and the Manhattan Maternity Hospital and Dispensary. Because work perpetuating objects of the two latter institutions will be taken over by the New York Hospital, their assets have been made available for the project through that institution, by action of their boards.

The project consists of 11 building units, having approximately 28,000,000 cubic feet of space. The plans as originally conceived called for 13 building units, but three city blocks did not provide space enough to set each upon its own ground plot and have sufficient intervening space for light and air. The problem was solved by piling three units of the project, one on top of another, a unique venture in hospital planning. This "three-unit" pile is the main building of the hospital which has as its base the general hospital building. Set on top of this is the private hospital on which is superimposed the third unit, the living quarters building for the residence medical staff which has its "foundations" seventeen floors above the ground and sweeps up to a final height nearly as great as that of the Washington Monument. Although each of these units is now structurally part of the main building, this building is so designed that each will be self-contained, having its own private elevator service and, in the case of the two hospital sections, its own facilities for reception of patients.

Dominating the entire develop-

The accompanying description of the New York Hospital-Cornell Center was supplied by representative of the association operating the center in advance of the formal opening of the center which took place early in September, following a "pre-view" by leaders in hospital, medical, nursing and allied fields on August 31. This latest metropolitan medical and hospital center will be of widespread interest and will be the goal of all who visit the East in search of newest features of hospital plan and construction.

ment, the daily population of which will average 3,000 patients, doctors, nurses, college faculty, medical students and employees, will be the main hospital building, 27 stories high. Facing 68th Street and set back 130 feet from the sidewalk, it stands in the middle of a single plat covering the two-block area between 68th and 70th Streets. The main entrance will be on 68th Street. Around the central building of the hospital will be grouped the medical school buildings and three special hospitals for pediatrics, maternity and psychiatry, all of which with the exception of the psychiatric hospital, will be structurally joined to the main building. In the block between 70th and 71st Streets will be the nurses' residence, and a large compound building which will house an employees' dormitory, the power plant, a parking garage, the laundry and general service facilities. These two buildings are to be connected with the main group by tunnels under 70th Street.

The completed project will contain approximately 1,000 patient beds, quarters for a nursing staff of between 500 and 600 nurses, and facilities for housing 125 resident doctors and for the instruction of about 300 undergraduate medical students, and a relatively large number of graduate students. In addi-

tion, there will be living accommodations for 200 employees. The dispensary will accommodate 1,000 patients daily.

The buildings occupy approximately 272,250 square feet of ground or about six and one-quarter acres. The gross floor area totals 1,963,700 square feet or 45 acres.

Excavation for the medical center involved the removal of approximately 310,000 cubic yards of rock and earth, including the blasting out of 350,000 tons of rock, one of the largest single excavating jobs, exclusive of subways, ever undertaken in New York City. In places the excavations reached a depth of 40 feet, or 9 feet below the level of the East River at high tide.

Used in the construction of the center were:

- 23,000 tons of structural steel.
- 6,700,000 face brick.
- 90,665 barrels of cement, excluding the special cement used for arches.
- 99,212 cubic feet of limestone, 3,300 cubic feet of marble and 14,630 cubic feet of granite, or a total of 9,204 tons of stone for the exterior.
- 51,897 square feet of marble, Ridgeway Flag and Crab Orchard stone for floorings.
- 13,000 square feet of Crab Orchard stone wainscoting.
- 110 miles of pipes for plumbing.
- 940 miles of electric wiring, not including elevators or telephones.
- The buildings contain:
 - 35 elevators, which will travel 153,300 miles and carry 2,500,000 persons annually.
 - 6 oil storage tanks with a combined capacity of 135,600 gallons.
 - 6 water tanks with a combined capacity of 275,000 gallons.
 - 149 electric ventilating fans in the ventilating system.
 - 20 miles of metal air ducts, with a capacity sufficient to move 1,468,000 cubic feet of air a minute.
 - 264 laboratories.
 - 8,103 windows.
 - 25,000 electric light bulbs.
 - A refrigerating plant of 300-ton capacity.
 - A parking garage for 250 cars.
 - A complete power plant, with four boilers, of a combined rating of 3,200 horsepower.
 - 8,400 plumbing fixtures.
 - 9,200 doors.
 - 31,898 lineal feet, or 5.4 miles, of corridors.
- Operation of the hospital will involve:



The washing of 4,420,000 pounds of linen a year.

The annual production of 400,000,000 pounds of steam for heating, sterilizing and power, and 7,000,000 kilowatt-hours of electricity, enough to light all the homes in a community of 42,200 private houses and heat close to 1,100 others.

A complete change of air every twelve minutes, all air entering the ventilating system being filtered, washed, heated and humidified.

The burning of 3,450,000 gallons of fuel oil.

The main hospital is an H-shaped structure consisting of a central building containing the three self-contained units already referred to. The first 11 floors of the main building will be a complete general hospital, housing all the general wards, and two operating room floors, one on the tenth floor for ward use and one on the eleventh floor for private patients. The twelfth to the seventeenth floors will be devoted to private patients and, like the ward section, will be a hospital in itself having a special kitchen for private patients and a special dining room, reception and visiting rooms. On the upper floors are to be located the living quarters for the resident staff of the hospital as well as recreation rooms.

In the basement and sub-basement of the central building will be general kitchens and special diet kitchens, together with the equipment needed to handle the extensive records of the center. Because of the contour of the medical center site, which slopes off 27 feet between York Avenue and Exterior Street, the basement of this building, as well as of the three special hospitals ac-

tually will be above ground, and sunken gardens on the 68th Street side will afford an attractive view even from its windows. Because of this fact, it has been possible to make use of this level, among other things, as the receiving entrance for the out-patient and ambulance cases. Administration offices and the reception hall for ward patients will be on the ground floor.

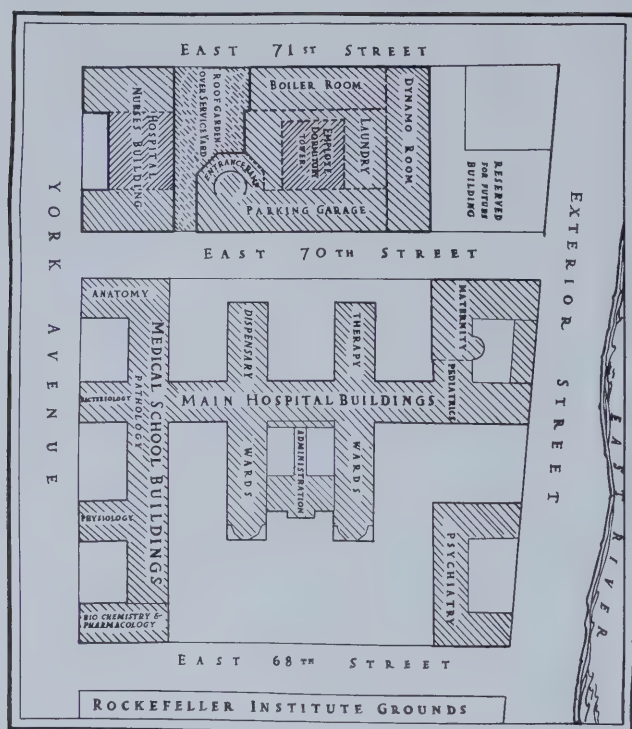
The H-shape of the main building is the result of four wings jutting out from the central portion of the building on the north and south sides. The two southern wings, facing on 68th Street, are nine stories high and will contain the medical and surgical wards of the hospital. The two northern wings, likewise

nine stories high, are to be devoted to the therapy and dispensary services most closely corresponding with the nature of the wards on the same floors of the southern wings. The floors for the general medical wards, for instance, will be the same as those for the medical branches of the out-patient department, enabling the greatest degree of co-operation between the resident and part-time members of the hospital staff. The other northern wing will be given over to the special facilities for the various therapies, the department of radiology and the emergency service, thus making each of these services equally available for both ward and out-patients.

Including a large amphitheatre,

The Medical Center in Figures

- 11 separate buildings; 28,000,000 cubic feet of construction.
- Main building 27 stories, 11 lower floors general hospital; 12th to 17th floors private hospital; upper 10 floors personnel quarters.
- Laundry equipment to handle 4,420,000 pounds of wash a year.
- Garage for 250 cars.
- Separate maternity building for 175 patients.
- Separate pediatric building for 130 patients.
- Nurses' residence, 16 stories, 500 to 600 nurses.
- Medical school plant for 300 students.
- 32 operating rooms.
- Dormitory space for 200 employees.
- Three generators, each driven by 2,500 horsepower.
- Refrigerating equipment with capacity of 213 tons.
- 5,493 radiators, with rating of 263,467 square feet of surface. 230 radiators in fan heaters, with equivalent of 228,640 square feet of surface.
- Plant will have average total daily population of 3,000.



there will be 19 operating rooms in the main hospital, for ward patients and six for private patients. They will be concentrated, for the most part, on the tenth and eleventh floors, which will separate the general from the private hospital section. In addition, there will be special operating rooms in the maternity and pediatric hospitals, the former also being provided with four delivery rooms and six labor rooms, bringing the total operating rooms for the center to 32.

Directly to the east of the main building, and facing on Exterior Street, will be the Pediatric Hospital, an eight-story structure to contain approximately 130 beds, an extensive out-patient department, and complete facilities for the study of medical problems peculiar to this particular field of medicine, and for instruction of students. Adjoining it, on the corner of 70th Street, will be the Maternity Hospital, likewise fully equipped for teaching and research purposes as well as for the best possible care for the women and infant patients. This hospital, a memorial to the late Laura Spelman Rockefeller, mother of John D. Rockefeller, Jr., will provide approximately 175 beds for obstetrical and gynecological cases.

The service of the Psychiatric Hospital, at the corner of 68th Street and Exterior Street, will extend into all departments of the main hospital and out-patient clinics, as well as into the various departments of education and research of the Association. In addition to being an integral part of the center, the Psychiatric Hospital will also collaborate both in the care of the sick, in teaching and in research with the staff of the Bloomingdale Hospital, the psychiatric branch which the New York Hospital maintains at White Plains, N. Y. The Psychiatric Hospital will have its own out-patient department, with special provision for field work in mental hygiene and social service work in the interest of persons suffering from nervous and mental ailments.

To the west of the main hospital will be the medical college group which, although containing five units, will virtually be one building having for its central portion the pathology building of seven stories which will be joined to the main hospital. Four wings, each five-stories high, and housing the departments of bio-chemistry and pharmacology, anatomy, public health, bacteriology and physiology, will face on York Avenue. The College build-

ings have been so constructed as to allow for erection of additional stories on them in the event of expansion of the College in the future.

The nurses' residence, and the employees' dormitory, power plant, laundry and garage, which are being constructed in the block between 70th and 71st Streets, represent one of the most extensive undertakings for housing and service facilities ever designed for a unified private project for the care of the sick, research and medical education.

The nurses' residence, a 16-story structure along York Avenue, will house about 500 nurses. In the design of the building every effort was made to provide conditions that would maintain health and high morale. Each nurse will have a private room, and the windows of all rooms will face the outside of the building.

The recreational equipment of the building will include a spacious gymnasium in the basement and a large central living room and social hall on the first floor. The building also will contain, in addition to living quarters, the kitchens and one large dining room, the administrative offices, a large assembly hall, demonstration rooms, library, laboratories and other educational facilities.

The employees' dormitory will be superimposed upon a broad base of a compound 4-story structure made up of the power plant, the laundry, and the garage which will serve the medical center. The power plant will generate all the heat, light, power and refrigeration service required by the entire center. To give some idea of the size of this plant, the central refrigeration unit alone will have a total capacity of 213 tons, providing 20 tons for ice-making, 118 tons for air conditioning, and 75 tons for general refrigeration, including kitchen and drinking water service. The electrical requirements of the center will be furnished by three generating units, with space reserved for two more, each driven by a 2,500 horsepower engine. The heating system for the center, likewise taken care of by the power plant, contains a total of 5,522 radiators having a rating of 251,900 square feet of surface. In addition, there are also 230 radiators in fan heaters, with a direct equivalent of 228,040 square feet of surface. The laundry, which also is located in the employees' dormitory building, will have a capacity for washing 4,420,000 pounds of linen a year.

In order to prevent traffic congestion and undue noise in the vicin-



ity of the center, four floors of garage space, for parking purposes only, will be provided on the 70th Street side of the employes' building. The garage will accommodate 250 automobiles. The construction of this lower part of the building has been so designed as to insulate its sounds from the dormitory portion which will completely surround and hide the 405 foot stack of the power plant. To avoid the unsightly and noisy conditions which would occur by reason of the use of the space between the employes' dormitory building and the nurses' residence as a service yard, the area will be roofed over and converted into a roof garden, one of three which will add to the beauty of the center when it is completed.

As provided for in the covenant, the medical center is and will continue to be governed by a Joint Administrative Board composed of three governors of the New York Hospital, three representatives of the University and a seventh member elected by the other six. This arrangement, and the powers entrusted to the board, assures the unified control essential to the effective functioning of the center at the same time that the two institutions retain their separate corporate identities and financial independence. The New York Hospital however, holds title to the land, is erecting the buildings, and has assumed primary responsibility in providing and obtaining the funds needed for construction and adequate

endowment of the medical center. A large portion of the money which made possible the entire development was provided through the hospital by the gifts of the late Payne Whitney, who for many years was vice president of its board of governors.

The Joint Administrative Board has been empowered to formulate general policies and plans; have visitorial powers over both units of the Association; supervise all medical education conducted by the university; act as a board of adjustment between the units; apportion to each its proper share of the expense incurred; and approve all nominations to the professional staff of the hospital and to the faculty of the medical college. The center will function on what is known as the university basis, with the same

"The hospital building is planned for a life of not less than 100 years, and for the achievement of such longevity all arteries carrying water, heating, steam, electricity, gas and ventilating lines are so placed and constructed as to be easily accessible for repairs or replacements at any time. All these lines, furthermore, are capable of carrying double the normal load which ordinarily will be required."

group of men who minister to the sick in the hospital conducting the teaching and research of the medical college.

Representing the New York Hospital on the Joint Administrative Board are Edward W. Sheldon, president of the hospital; William Woodward and Frank L. Polk. The university representatives are Dr. Livingston Farrand, president of Cornell University, J. DuPratt White and Dr. Walter L. Niles. J. Pierpont Morgan is the seventh member.

Dr. G. Canby Robinson, dean of the Cornell Medical College, as director of the association, is the chief executive officer of the entire project. Wallace Lund, formerly associated with various Rockefeller philanthropic organizations, is assistant to Dr. Robinson, and is in charge of personnel organization for the center, which will be accomplished on the basis of departmental units.

Coolidge, Shepley, Bulfinch & Abbott, of Boston, are the architects for the medical center, and Marc Eidlitz & Son, Inc., of New York, are in charge of construction

PHILADELPHIA COMMITTEE

Mayor Moore of Philadelphia recently named a committee headed by Dr. J. Norman Henry, director of public health, to study the problems of city and private hospitals. The other committeemen are: C. S. Pitcher, superintendent, Presbyterian Hospital; J. N. Hatfield, superintendent, Pennsylvania Hospital; Miss S. C. Francis, superintendent, Children's Hospital; Dr. William H. Long, medical director, Misericordia Hospital; Dr. John D. McLean, superintendent, Rush Hospital; Dr. M. F. Moselle, superintendent, Douglass Hospital; Dr. Henry M. Minton, superintendent, Mercy Hospital; John M. Smith, director, Hahnemann Hospital; Melville L. Sutley, superintendent, Delaware County Hospital.

REFRESHER COURSE

Dr. A. K. Haywood, superintendent, Vancouver General Hospital, Vancouver, B. C. was the featured lecturer at a refresher course for nurses at Vancouver. His talks were on organization, classification, function of hospitals, hospital organization, method of approach to a building program, importance of personnel of telephone office, information desk, admitting office; methods of dealing with complaints, publicity, etc., food services, kitchen equipment—central vs. ward food service, food conservation, etc., fire protection, outpatient department, social service, laundry, purchasing and office management.

HOSPITAL HOUSES NURSES

It is announced that the Methodist Hospital, Indianapolis, will furnish rooms for nurses attending the thirtieth annual conference of the Indiana Nurses' Association October 5-8, for \$1 a night. The rooms are on floors unoccupied. Meals for the nurses will cost from 20 cents to 50 cents.

"Sure, Hospitals Should Sue 'Dead Beats' Able, But Unwilling to Pay"

Writer Urges Courageous and Firm Policy
With Delinquents Who Deliberately Attempt
to Evade Payment When Able to Remit

By JOHN E. LANDER

Financial Secretary, Wesley Hospital, Wichita, Kan.

IS a community hospital ever justified in forcing collection from those able to pay?

Every such hospital has or should have a policy in regard to the payment of accounts. In arriving at a policy, one should first discover what the charter has to say concerning the nature of the business to be transacted and from what source or sources the money necessary for operating the hospital is to come.

Some of the things granted in a charter of an ordinary benevolent hospital are:

"To enable this organization to carry out its purposes, it shall have power to acquire by purchase, gift, devise, bequest or otherwise, real and personal property of every kind and nature and to hold, use, lease, mortgage or dispose of the same to the best interests of the institution."

Also:

"This institution shall be authorized to require and receive from all patients who are able to pay, such compensation as may be necessary to meet the expense of nursing care, board and medical supplies furnished by the hospital."

These charter provisions emphasize two things:

First, that the institution has the right to obtain gifts of property and money. These are used primarily in the building of the institution, and as secured, go into what is known as the building fund.

Second, that those able to pay the hospital for services rendered shall do so. Therefore, a hospital, under its charter, is justified, where necessary, in forcing collection from those able to pay.

For instance, here is a man, say, thirty-five years of age, has a paying business, but has soured on life because of domestic difficulties. He refuses to pay his wife's hospital account, which was incurred before divorce proceedings were instituted. Such a man's excuse for refusing to pay a hospital bill is more because of his grouchy feeling toward his wife than for any other cause, and the hospital is not responsible for

that nor should the hospital be penalized therefor.

In a case like this, everything possible is done to collect, and decision must be made as to whether the account will be lost or suit instituted. A judgment is obtained. A garnishment fails to produce, and the matter for the present is forgotten.

But in about thirty days our erring brother walks into the office, sits down, and in a nice, friendly fashion we talk the situation over. Our reasons for proceeding as we did are quietly, but firmly explained. Our brother acknowledges he is wrong and that our filing a notice of judgment on his card at the credit association is affecting his credit standing in the community, that the account should really be paid. Arrangements are made accordingly. The brother thanks us for having taken the stand that we did and he continues to be a friend of the institution. We will get his patronage in the future and he will gladly pay for services rendered.

This is the fifth and concluding article of an interesting "brass tacks" series on ways and means of improving hospital collections. The earlier articles dealt with the proper basis for collections, which is a thorough understanding of the terms and the amounts at the time the patient is admitted, with the importance of strict adherence to these terms and conditions by the hospital accounting or credit department, with the handling of patients who leave without paying in full, with the value of cooperation with a local credit bureau, and other topics. In the final article the handling of "deadbeats" and the advisability of instituting suits are discussed.

A failure on the part of the hospital to force collection in such a case would have lost the account, would have lost the respect of the debtor, would have lost his future business, and would have contributed toward his permanent delinquency pertaining to the handling of future accounts, for if he could have "got by" with us he would have made a start in the wrong direction.

Take the case of a young woman who guarantees the payment of her mother's hospital account, then leaves for a distant state and ignores all communications. What should one do, lose the whole account? No. Give it to your local credit association with instructions to forward to a cooperating association and see how it feels to have a check in full inside of sixty days.

Here is a man who is indebted several hundred dollars for services rendered. He acknowledges his life was saved by the hospital and seems very appreciative. The months go by and finally after many promises the hospital finally insists on settlement. Then the true nature of the debtor is learned as he refuses to pay the bill, alleging that he was overcharged. Just a pure bluffer, unappreciative, insolent; but the next day when he is served with notice of suit in order that he might be given an opportunity to prove his statements, how different he is and how he now wishes to settle. It's a rank injustice to the man himself to fail to bring suit in a case like that.

Then there is the fellow who gives you a "hot" check. Why let him "get by" with it? Why not give him a lesson? It might help him a lot. The writer has collected many such checks, but in only three cases have warrants ever been issued, and in all three cases payment in full was made with costs added.

An institution or a merchant that fails to use the law in cases like these really contributes toward the offend-

"Should Hospitals Sue Delinquent Patients Who Are Able to Pay?"

"Many hospitals, under their charters, are justified, when necessary, in forcing collection from those able to pay."

"When should such a delinquent be sued? Whenever one's chances of collection can be improved by so doing."

"There are cases where suit would be advisable even though collections were not made through court processes, because it proves to the erring debtor that he can't impose on the hospital."

"We have no right to let those able to pay evade payment, for in so doing the poor but honest not only pay their bills, but also help to pay for the dishonest delinquent whose feelings we sometimes are 'afraid we'll hurt.'"

"There are some timid hospital officials who would not force collections from those able to pay because they are afraid people would talk and criticize the hospital. Well, who is going to talk? Surely not the delinquent themselves, and if the story did get out, no fair, upright citizen is going to find fault with the hospital for doing its duty. To the contrary, the institution would be congratulated for common sense, courage and impartiality."

ers' delinquency. If they couldn't "get by" with it, they would soon learn that it didn't pay.

One might ask, when should a delinquent account be sued? Whenever one's chances of collection can be improved by so doing. Sometimes it is necessary to garnishee a debtor, but only as a last resort.

There are cases where suit would be advisable even though collections were not made through court processes because it proves to the erring debtor that he can't impose on you and he will not be likely to "repeat"; and if he needs hospitalization later, the chances are it will be a cash transaction.

In the collecting of accounts there is a great deal of satisfaction in knowing that you have been kind and fair in all cases, but firm and persistent where those qualities were necessary.

Someone has said, "Be sure you are right, then go ahead!"

Another says, "Be sure you're right, then ask your wife," but in dealing with a delinquent debtor be sure you have been kind, fair, and lenient, but when the proper time comes, tighten the screws. Do this for the sake of your institution; that it may be respected. Do it for the sake of the delinquent debtor; that he may be helped to see the "error of his ways." He is worth saving.

Here is a young man from a good family, who lives in a \$20,000 home. He brings his wife into the hospital, demands the best of everything, runs a bill of \$200, and you are dum-

founded when the bill isn't paid and again later when many promises to pay are not kept. The young man simply ignores you. He perhaps feels that the "standing of his family" is such that collection will not be pushed. But he gets a surprise. The case goes for collection, and when convinced that suit will be instituted he finally pays the bill, plus interest and other extra charges that had been incurred. Thus far in the young man's life this was perhaps the best lesson that has come to him and should go a long way in teaching the pampered youth that he should put some of the Golden Rule into his dealings with his fellow man and to help him to remember that there are some other people in the world who have rights that should be respected.

Here is an accident case. The patient refuses to pay, pending suit settlement with the party who "ran into" him. The hospital waits patiently month after month, feeling absolutely sure that if the money goes from the insurance company

into the hands of the patient, the hospital will never receive a penny. After judgment has been rendered and the insurance company expressed a desire to pay, should we sit idly by and see the money get away or stop the money from leaving the hands of the insurance company until our claim is paid? A failure to sue in a case like that and permit a \$300 loss to the hospital would be unpardonable.

There are some timid hospital officials who would not force collections from those able to pay because they fear people will talk about it and criticize the hospital. Well, who is going to "talk about it"? Surely not the delinquents themselves, and if the story did in any way get out, no fair, upright citizen is going to find fault with the hospital for doing its duty. To the contrary, the institution would be congratulated for common sense, courage, impartiality.

Righteous indignation sometimes surges through a fellow's soul when he sees the poor though honest man, with a small wage, shabby clothes, a large family, come in month after month with his chin up to pay on his account, when perhaps the next card in the file contains the name of some "society bee," twenty times more able to pay, but who because of his "standing" in newspaper columns thinks he can ignore his accounts with impunity.

Yea, verily, we have no right, either before God or man, to let those able to pay "get by," for in so doing the poor but honest not only pay their own bills but also help to pay for the dishonest delinquent whose feelings we are sometimes "afraid we'll hurt."

Be fair, courageous, impartial, unafraid, and don't lower your standards because some "two spot" threatens to criticize you for doing your plain duty.

MISSISSIPPI HELPS

The Mississippi Board of Hospital Inspectors was created by the last session of the Legislature. This bill grew out of a community hospital program promoted by the Mississippi State Medical Association. The money appropriated is small at this time, but hospital leaders of the state think this is the beginning of a program which will prove most beneficial in future years to the hospitals by way of added monies provided through the state Legislature. The bill provides for small appropriations to help hospitals approved by the board to meet the cost of service to indigents. The board of hospital inspectors consists of three members, one each representing the hospital, the medical and the nurses' associations of the state. W. Hamilton Crawford, superintendent, South Mississippi Infirmary, Hattiesburg, is the hospital member of the board.



Looking at a Hospital Bill From the Outside, and Inside

Here Is an Interesting Presentation of the
Hospital's Viewpoint on Costs of Service

By ROBERT HUDGENS

Assistant Superintendent, Wesley Memorial Hospital, Emory University, Ga.

IN America during the current year one out of every ten families will find it necessary to place one or more of its members in hospitals. Unless charity service is obtained, the patient will receive the obnoxious hospital bill. In most cases it will be thought high—in many cases exorbitant.

The difficulty arises from the fact that there are two views. The average layman stands on the outside and looks in; the hospital official sees the problem from within. Accordingly, the picture changes as the vantage-ground shifts.

The lay viewpoint is well represented by this protest, which recently appeared in a local newspaper. "Forty-five dollars per week for room and board is, I believe, an exorbitant and unreasonable charge for a small and scantily furnished room, and the amount of food an ill person consumes. The best American plan hotel would not have the nerve to charge any such price as this; and if by chance a person did happen to be summering at a hotel where prices were this high, you would expect the utmost in service and the best of food. But what does a patient in a hospital receive? Just room and board—that's all."

Thus it appears from without. Let us now take a look from within. Since most people are generally familiar with hotels, and insist upon comparing hospitals to them, we can do no better than examine their differences.

For a room in the average, reputable hotel one pays from \$2.50 to \$4 a day. This sum does not include meals, and offers only the furnished room and bath. All telephone calls, laundry, valet and other services come extra. Even when ice water is brought in, the bell boy deftly displays the palm of his hand, and lingers until it is observed.

Nothing is here offered which is not likewise present at a hospital, unless it is the bath. Small use for a

bath has the patient who moans under the misapprehension that all his vital organs have been removed; but a bath is obtainable when desired, though at slightly additional cost.

Upon arriving at the hospital the patient has considerable option as to accommodations. In most sections he may obtain a ward bed at \$3 a day; a semi-private at \$4; and private rooms ranging in cost from \$5 to \$8 a day. Regardless of which he takes he gets essentially all that a hotel offers. Though the ward patient sacrifices privacy, he gets for his \$3 a day all the food his doctor allows, plus many other things of which the layman seldom thinks.

However, to avoid either extreme, let us use for illustration a private room costing \$6 a day and inquire what the patient gets without extra costs for his money.

He gets a room with running hot and cold water, if not bath. He gets those other furnishings, and fixtures common to hotels. He gets a daily change of linen—oftener if necessary.

He gets regular meals if his condition permits. Much is made of the fact that a sick person pays for food which he may not be able to eat, but it is seldom considered that he becomes the more expensive when he cannot have regular meals. He must be nourished. When the regular prepared meal cannot be served, the hospital must prepare a special one. Frequently special delicacies are demanded, whether they be for the patient's mental or physical welfare. Strawberries in January or spring chicken in mid-winter are not purchased in a favorable market. Calf liver is dearer than roast beef, especially when it is not a menu item, and must be bought and prepared for a single serving. Whatever it is, if at all procurable, the patient expects to have it, and have it in lieu of his regular meal.

It is conceded that various hospitals have different policies with respect to charging for special diets. The institution of my connection makes one

exception. When pure cream is used in quantities, the patient pays its purchase price. All else is without extra cost. The fact remains, however, that whether or not the sick person eats his regular meals, he successfully contrives to see that he gets his money's worth. Not infrequently he falls upon the happy expedient of having visitors partake of that which he refuses.

Surgical cases must be dressed. These dressings, gauze, adhesive, sponges, and rubber goods must be sterile. In addition scores of medicines are stocked on the floors, and are available for treatment. They, too, are a part of the \$6, though especially compounded prescriptions ordered by the attending physician are charged to the patient. Seldom ever does the patient realize the investment necessary to provide ready at hand the medications, the instruments, the dressings, the specialized equipment necessary for his welfare. No patient uses it all, but it all must be there in case he needs any part of it—all for \$6.

That \$6 assures the patient of attention 24 hours every day. To provide this service the hospital must employ some two persons for every patient. Day and night graduate and student nurses must be available. Day and night there must be resident physicians, and interns. Day and night there must be maintenance men. Day and night there must be cooks to provide needed nourishment. \$6 covers it all.

"True," you concede, "but it is the total of extra charges that eats us up."

Necessarily there are extra charges. All patients have need of the services furnished under the room charge, but not all must have X-ray work, or surgery. It is only right, then, that those who use the operating room pay for it. But are these "extras" too costly?

A typical case will best answer the question. Let us see what extra

charges adhere to the patient who must part company with an appendix. He will be in the hospital perhaps two weeks, fourteen days. Multiply 14 by his \$6, and the patient has a basic bill of \$84. In addition, he will pay some \$20 for the operating room and anaesthesia. It costs approximately \$2,000 to fit this room out for his and similar cases, but we will here concede that this sum has long ago been liquidated. We shall confine ourselves to the more expendible items.

If the patient could see the numerous instruments to be applied to him, he would be horrified. Forceps, scissors, needles, suture material, gauze, cotton, gloves, and harsher sounding articles must all be assembled for the operation. A copious supply of towels and sheets is on hand. Everything must be sterilized. After the operation all material which can be re-used must be cleansed, polished or otherwise treated.

Assembled for the event are four or five or six nurses, and one or two house surgeons. A trained anaesthetist sits at the patient's head, watches his every symptom, and manipulates an apparatus, the cost of which runs into several hundreds of dollars. For thirty minutes or an hour all these things and people work for him, while the hospital stands the cost. Is a bill of \$20 high?

The total is now \$104. To be generous, add five to ten dollars more for prescriptions and routine laboratory examinations, and you reach a final figure. Really is it high? Remember that a \$6 room was taken. The bill could have been increased; it could also have been lowered, but this the patient decided, not the hospital.

Hospital rates, like those of any other industry, are arrived at upon the accepted economic principle that a concern must have an income from its expected volume of business sufficient to cover its operating and overhead expenses.

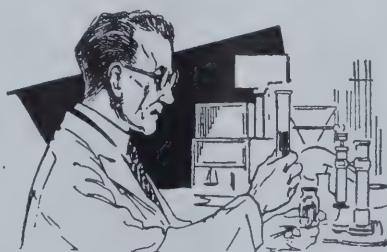
With hospitals there is one very material difference. In the majority of cases they do not expect a profit. They merely strive to balance their budgets. The public is further benefited by the fact that philanthropies have greatly lessened the load the public must carry. Many hospitals have some endowment, though the amount varies greatly. In addition, buildings and equipment have often been donated, or some form of subsidy has been effected. Such benefits, plus the fact that profits are ordinarily not expected, can only mean that rates are lower than would be necessary if the institutions were exclusively dependent upon the sick within their

"The layman, standing without, seldom pauses to ponder the complexity of a modern hospital. It is this complexity which so expands overhead cost. One institution, admittedly not mismanaged and representative of most, closed its books for the year, showing an average for the twelve months of 117 patients a day. To care for these patients, it was forced to spend for the year \$108,900 for salaries and wages; \$2,500 for printing and office supplies; \$2,300 for telephone and telegraph service; \$1,800 for insurance; \$8,500 for house-keeping and linens; \$12,800 for heating; \$16,000 for laundry; \$5,300 for electricity; \$2,325 for water; \$15,000 for medical and surgical supplies, exclusive of drugs; \$3,850 for X-ray and laboratory supplies; \$78,000 for food, and some \$16,000 in uncollectible accounts. These are merely representative expenditures and are by no means inclusive of all items of overhead."

doors. It can, therefore, be said that however much the patient pays he still receives something for nothing.

Of these things the patient does not think. His attention is focused upon the sum he must pay. To most of us an item is high in proportion to its desirability. What we really want we are willing to pay for, and if the cost is a little too exciting we merely brag the louder. We will deplete our cash reserve and mortgage our incomes for twelve months in order to possess title to a \$125 radio. This we will do gladly, but into what an apoplectic state we go when the hospital sends an equivalent bill! The truth is, had it not been for the hospital and medical care, the radio payments might have out-distanced us. Then confound the hospital! The radio was wanted; the infection wasn't. And what a difference that makes!

The last thing people do, and many never do it, is to include in their



budgets an allowance for the expenses of illness. Consequently, when sickness comes few are prepared for it. For the first time, perhaps, the family learns how much cheaper health is than the pursuit of it. Resentment is felt that this thing should have befallen, especially at such a time. In the consequent strain, compounded of suspense, weariness and overdrafts, a bill takes the form of a deliberate insult. And of course it is too high!

Very frequently I hear someone, in complaining of hospital costs cite some figure which is obviously too high for the stay and treatment involved. Questioning usually discloses a misrepresentation. Into the supposed hospital bill has been added the doctor's fee and the cost of special duty nurses. These are not hospital charges. Doctors and special nurses are privately contracted for. The inclusion into the hospital bill of such cost, though they are usually reasonable, only adds to the popular but erroneous belief that hospitals are unjustifiably high.

After all, the true criterion of whether hospital costs are exorbitant is the worth of the service rendered. A monetary value cannot be placed upon human life. If the facilities of the modern hospital make possible the prolongation of one's life, the cost at any figure is cheap. Hospitals are striving daily in multiple ways to make this service cheaper, but illness is ultimately a social problem. Unless the well and affluent members of society will accept the cost obligation, it will continue to revert to hospitals, and allied fields. If they are forced to accept the responsibility of furnishing to the afflicted facilities of cure, they must necessarily place the cost back upon the beneficiaries. It is expensive for all concerned, but if too much so, society as a whole must be indicted and not the individual cross-section which has the fault of being the most Samaritan-like.

ALL ABOUT MILK

The White House Conference on Child Health and Protection, recognizing that milk is a vital factor in the development of the growing child, included in its activities an investigation of the public health, the nutritional and the economic aspects of the milk supply of this country. The results of this study, which have a vitally important bearing upon the health and welfare of children, is clearly and fully reported in "Milk Production and Control," The Century Company, New York, price \$3.

One section of the book treats communicable diseases transmitted through milk. A second section deals with public health supervision of milk. The two other sections consider the nutritive properties of cow's milk and milk products, and the economic aspects of milk.



Will the College-Trained Nurse Supplant the Doctor?

By SISTER JOHN GABRIEL

Director of Nursing Education, Sisters of Charity of Providence, Seattle, Wash.

THE article, "More Student Nurses Despite Fewer Schools in Some States," that appeared in *HOSPITAL MANAGEMENT* (May, 1932) seems to indicate that closing the schools of nursing is not an answer to the question, "How shall we reduce the number of student nurses?"

It has been reported that 90 schools of nursing closed recently in this country, yet notwithstanding this movement to help keep so many nurses out of an over-crowded field, the Grading Committee discovered that 25,000 new graduates went into the profession this year and there is a possibility that approximately the same number will be available next year. It may be that 1934 will mark the change in numbers of graduates and show the results of fewer schools, but it is the experience of those of us who are administrators that when a girl decides to be a nurse she means it, and she will leave no stone unturned until she finds her way into the profession. This is not an intelligent way of choosing a life work, I will admit, but up to now, however, it has been the mode of procedure; even when a student was let out of a school because she was thought not a desirable subject she knew that there

were other schools ready and willing to open their doors to her and allow her to graduate.

Perhaps the closing of schools of nursing indiscriminately is not altogether the panacea sought to uplift the nursing profession any more than it does lower the numbers of those entering it. A better approach to this problem would appear to be, raising the entrance requirements and if possible fixing these requirements by means of state legislation. This is no child's play; it is hard to get legislation and most difficult to make our citizens understand that a nurse needs a university background if she is to maintain her status as a professional woman. Every profession, apart from the nursing profession today, exacts that its applicants have some university training previous to taking up the work of the professional school. There are those among us who feel that a university education will make the nurse usurp the place of the doctor, but a moment's thought will disclose the fallacy contained in this idea. Why should higher education make a nurse usurp the place of the doctor more than it made the doctor usurp the place of the lawyer or the clergyman?

The rapid strides that have taken place in scientific medicine make it almost imperative that a nurse, to understand the language of the doctor of today and carry out his orders, bring such a preparation to the professional school as will give her a good grasp on the basic sciences, a good command of the mother tongue in addition to that degree of culture that will allow her to move easily through the different forms of society encountered in the practice of her profession and to help her appreciate the finer things in life. These qualifications are largely obtained through a college education; therefore it would seem that to ask an applicant to present an evidence of one year, at least, of university work over and above a high school record showing the completion of four years with a standing in the upper third of her class, is not an exorbitant requirement for a profession that is concerned with such important issues as human lives.

The year of university work should be taken at the student's expense and the curriculum should provide such subjects as are applicable to a nursing course. Such a process, it would seem, should help to reduce the number of those who are now applying to the schools for what appears to be a "home" until depression passes over; it would also provide an older and more responsible applicant as well as one with a broader experience and higher ideals.

This experiment is now being tried out at Providence School of Nursing, Seattle, Washington. That institution has recently issued a bulletin showing an entrance requirement of one year of university work in addition to the university matriculation, which was a requisition of former years. The applicant is now requested to present an evidence of having earned forty-five quarter credits or thirty-six semester credits in an accredited college or university; it further requires that the subjects taken be as follows: two courses in English, two in chemistry, one in anatomy, one in physiology, one in bacteriology, one in psychology, one in nutrition, one in nursing education, and one elective. This is all taken at the student's expense previous to entering the school, and there are no exceptions made regardless of who the applicant may be.

The length of the course has been reduced to two and one-half years, two years at the parent school and six months' affiliation distributed over experience with children, communicable diseases, and the out-patient department.

When Will Hospitals Utilize Air Conditioning?

By CHARLES A. LINDQUIST
Superintendent, Sherman Hospital, Elgin, Ill.

WE have long recognized that both dust and noise have a profound effect on both the well and the sick, but like many other professional problems, the diagnosis has been simpler than the cure.

We have made marked advances recently in the use of acoustical materials to reduce noise created *within* our buildings, and we have highly efficient cleaning corps to remove dust *from* our buildings, but we have never succeeded in keeping either the noise or the dust out of our buildings.

Mr. Bacon has found that in order to keep noise and dust out, it will be necessary to have double windows and to keep them closed all the time. This immediately brings up the subject of air-conditioning and its consequent problems. Most everyone, when one speaks of air-conditioning, visualizes a huge plant connected with the central heating system. We are vaguely aware of the need of air-filters, washers, sprays, motors, fans, conduits, etc. These are appalling in their complexity.

At the Toronto meeting of the A.H.A. the subject was given much consideration and it was generally conceded that the only possible solution from the hospital standpoint was to treat each room individually. M. H. Olstad, engineer of the Niagara Blower Co., who read a paper on this subject at this meeting stated, "Some day we will apply in every room a small heating unit which will humidify the air, in summer will de-humidify it, will give us the necessary motion over the skin, the fan will be noiseless, and it will cost us no more money than the kind of makeshift apparatus we now use in our makeshift buildings."

It is such a unit which Mr. Bacon now offers us, but he has succeeded in developing the mechanical unit before the building engineers have succeeded in selling to the public the type of building which Mr. Olstad stated must replace our present structures. The American Society of Heating and Ventilating Engineers has by no means been idle for at this same meeting they reported on research work being done in Canada,

From a discussion of paper by Asa S. Bacon at Tri-state convention, Chicago, 1932.

where temperatures variations are extreme, which have proved conclusively that it is possible by varying our method of building construction to reduce the heating requirements of a building a full 60 per cent. This requires that walls and roofs have high heat capacity and low heat conductivity. Walls and roofs of this type will be considerably lighter than ordinary roofs and walls and there will be marked savings in the structural portions of the building which savings are expected to offset any increase in cost due to more expensive building material required for heat resistance.

If a saving of 60 per cent can be effected in our heating requirements this will help solve the cost of electricity, and opens the way for us to make use of the benefits of air-conditioning. Our knowledge of those benefits is as yet very meager but over four years of research work by Yaglow, Drinker and Blockfan has proved that air-conditions markedly influence the growth and development of premature infants. Also the application of air-conditioning to the nurseries is followed by a marked reduction in the incidence of diarrhea and in the mortality rate. Infections are reduced to a minimum and gains in body weight increased.

Yaglow in "Heating, Piping and Air-Conditioning" says: "The effect of humidity on comfort has not been satisfactorily established. There is no consistent research to show the response of adult human beings to controlled humidity conditions over a prolonged period of time. It is becoming more and more apparent however, that humidity exerts a considerable influence on the organism. A low temperature with a comparatively

high humidity is as a general rule more comfortable and probably more healthful than a high temperature with very low humidity. Extremes in humidity are undesirable because they produce a disturbance of water balance and evident symptoms of restlessness. Too dry air desiccates the skin and mucous membranes of the upper respiratory tract and this is believed to play a role in the incidence of respiratory disorders. On the other hand, when the relative humidity exceeds 85 per cent the organism cannot give off readily its latent heat. This latter effect is manifested not by a rise in body temperature, but by a decrease of about 20 per cent in the general metabolism."

Dr. A. C. Mills of the Department of Internal Medicine, Cincinnati General Hospital, in "Heating, Piping and Air-Conditioning," lists a few of the hospital's needs for air conditioning as follows:

1. For infants, especially the premature and delicate.
2. For children with summer diarrhea and other debilitating conditions.
3. For patients suffering from heat stroke or exhaustion, heart failure, etc.
4. For surgical patients to obviate the deleterious effects of summer heat.
5. For bronchitis and asthma—a dust-free, dry air.
6. Humid warmth for such over-stimulative diseases as hyperthyroidism, essential hypertension, acute or severe diabetes, and pernicious anemia. Also for excitable nervous states."

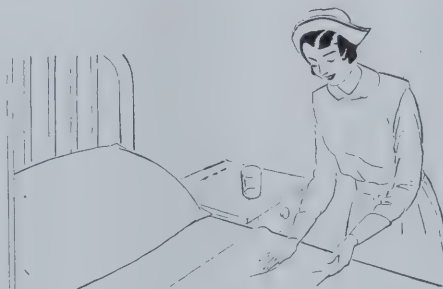
Air conditioning has arrived commercially not just in theaters and restaurants, but in many manufacturing plants and more recently in office buildings. How much longer will people be willing to suffer and endure unpleasant atmosphere conditions when in our hospitals?

CLEVELAND HOUSEKEEPERS

A meeting of the Cleveland Chapter, National Executive Housekeepers Association, was held August 9 at St. Luke's Hospital at the invitation of Dr. Wood, superintendent. Martha Woodhouse, executive housekeeper, and her assistant acted as hostesses. The members had an opportunity to witness the demonstration of a wall-washing machine, the only one of its type, performing miraculous work. The members were very pleased with the demonstration and are anxiously looking forward to further developments. Three new members have been accepted, Mrs. Katherine Ryan, Lakeside Hospital, Mrs. William Lutz, Mt. Sinai Hospital, and Mrs. C. E. Garthe, Bolton Square Hotel.

Mrs. Frey, president, made a report of the summer outing at Cedar Point and announced that Columbus is forming a chapter, with Mrs. Rhea Newquist being the first hostess.

The outstanding feature was the announcement of the Columbia University course. The Cleveland Chapter is waiting for instructions from the national association before proceeding with Western Reserve University.



Why Knoxville General Hospital Revised Staff Rules

By T. H. HAYNES

Director, Department of Public Welfare, Knoxville, Tenn.

WE are operating under the city manager form of government. The charter places full responsibility and authority on the director of public welfare for operating the hospital, including the naming of the staff of doctors. Our rules and regulations for the staff, as well as the house rules were inadequate and obsolete; the few we had having been adopted some ten years ago under a commission form of government.

The director of public welfare, the city manager, and the council agreed that a committee of citizens, composed of business men and doctors should be set up for the sole purpose of selecting and recommending to the director of public welfare, a staff of doctors to operate the medical and scientific departments of the hospital. Therefore, Ordinance No. 435 was passed by the City Council, February 23, 1932, creating the hospital advisory board for the above purpose.

Recognizing the need of new rules for the staff and hospital, Ordinance No. 435 further provided that immediately after the organization of the new staff, the chief appoint a rules committee to prepare rules and regulations governing the medical and scientific departments of the hospital. Said rules and regulations to be presented to the staff for its approval and recommendation to the director of public welfare and city manager, who in turn present them to the City Council for adoption. The Rules Committee secured the services of Dr. Bert Caldwell of the American Hospital Association and immediately compiled the rules which were passed as an ordinance on April 5.

The council elected to the hospital advisory board, Hon. Jas. A. Fowler, lawyer and former mayor, Mr. John Greene, a prominent business man, the Rev. Dr. Clifford Barbour, pastor of the Second Presbyterian Church, and Doctors Andrew Smith and Albert G. Kern.

Ordinance No. 435 reads as follows:

Section I: Be It Ordained by the Council of the City of Knoxville: That there is hereby created a Board of five members for the purpose of acting in an advisory capacity in the appointment of the staff for the medical and scientific operation of the Knoxville General Hospital. Said Board shall consist of five members, two

"In reply to the statement made by Dr. M. T. MacEachern, American College of Surgeons, that during the adjournment of the staff meetings of the three summer months, the Executive Committee are requested to meet each month and these meetings together with the record committee are being held regularly. They, of course, are empowered to act for the Staff and any matters that need to be discussed and any conditions that need to be rectified are attended to," explains T. H. Haynes, director, Department of Public Welfare, Knoxville.

of whom shall be physicians and members of the Knox County Medical Society, and three men, residents of the City of Knoxville, other than physicians. The Board shall be known as the Hospital Advisory Board and shall be elected by the Council. One member shall serve until July 1, 1933, two shall serve until July 1, 1934, and two shall serve until July 1, 1935. Thereafter, elections shall be for a term of three years. Any vacancy shall be filled by the Council, and shall be for the remainder of the term of any member failing to serve his complete term.

The Hospital Advisory Board shall meet immediately after its election and perfect its own organization by electing a president and secretary.

It shall within ten days after its election, recommend to the Director of Public Welfare, names of physicians to be appointed to the Hospital Staff for the remainder of the calendar year 1932. Thereafter the Board shall meet on five days' notice from the Chairman or Director of Public Welfare, except that the regular annual meeting for the appointment of the staff for the following calendar year shall be held during the second week in December, the exact date to be set and due notice given the members by the Chairman or Director of Public Welfare.

The Hospital Advisory Board in naming the Staff for the remainder of the year, 1932, shall consider as available all members of the Knox County Medical Society and as to the number named shall use as a guide the number recommended by the Superintendent of the Hospital who is familiar with the needs of the Hospital and who shall take into consideration the number required to operate the medical and scientific departments of the Hospital and the Out-Patient Department. Other appointments may be added to the Staff from time to time in case of emergency or need, upon the recommendation of the Executive Committee of the Staff (hereafter provided for) to the Advisory Board.

The Hospital Advisory Board in naming the Staff for 1933 and subsequent years shall receive from the Executive Committee of the Hospital Staff its recommendation as to the number of physicians needed to operate the various medical and scientific departments of the Hospital and Out-Patient Department. It shall consider the names of those on the Staff at that time and may receive and consider applications for membership on the Staff from other physicians who are not then on the Staff.

Section II: The Director of Public Welfare shall appoint to the Staff those named by the Hospital Advisory Board unless he has sufficient cause for failure so to do, it being the intention, however, that the Board shall act in an advisory capacity, and that final authority shall remain vested in the Director of Public Welfare, as provided by the Charter.

Section III: Be It Further Ordained, That upon the naming of the Staff for 1932, it shall be immediately called together by the Director of Public Welfare and shall elect a Chief of Staff, Vice Chief of Staff and Secretary. The Chief or Staff shall name a rules committee to prepare rules and regulations governing the medical and scientific operation of the various departments of the Hospital and Out-Patient Department. Said rules and regulations to be presented to the Staff for its approval and recommendation to the Director of Public Welfare and City Manager, who in turn shall present them to the City Council for adoption.

The Chief of Staff shall appoint an Executive Committee of three from the members of the Staff who shall have supervision and executive control over the medical and scientific operations of the Hospital and Out-Patient Department. The Chief of Staff and Superintendent of the Hospital shall be ex-officio members of the Committee. The Superintendent shall act as Secretary and keep all minutes and records of the meeting of the Committee.

Section IV: Be It Further Ordained, That pending the preparation and final adoption of other rules and regulations covering the operation of the Hospital, the rules heretofore existing and passed January 28, 1930, insofar as they do not conflict with this ordinance, shall remain in full force and effect.

That pending the carrying out of the provisions of this ordinance in the appointment of the staff for the remainder of the year 1932, the present staff shall continue to operate. But immediately upon the appointment of said staff for the remainder of 1932, all existing appointments and assignments now in effect shall thereupon and are hereby dissolved, revoked, repealed and rescinded.

Section V: Be It Further Ordained, That all ordinances or parts of ordinances in conflict with this ordinance be and the same are hereby repealed, and that this ordinance shall take effect from and after its passage, the public welfare requiring it.

TRIES INSURANCE

Inauguration of a hospital insurance plan, designed to bring hospital care within the reach of the average person, was announced recently by Presbyterian Hospital, Denver. Under the plan membership in the Presbyterian Hospital Association entitling the person to 21 days of hospital care during a year, is offered for \$9 a year.

Knoxville General Hospital Revises Staff Rules, Regulations

Outline of Staff Organization and Functions
Will Be of Interest to Other Hospitals
Contemplating Revision of Their Rules

PREAMBLE

In order to improve the professional service at the Knoxville General Hospital, to promote confidence in the administration of the hospital, and to develop in the best manner medical and nursing education and scientific research in medicine, it is deemed expedient and desirable to provide rules and regulations covering the operation of the staffs of the Knoxville General Hospital.

It is the desire and purpose of those responsible that the professional services in the hospital and the operation of the hospital shall be at all times organized according to the best hospital and medical practices, and in accordance with the standards of the American College of Surgeons.

STAFF ORGANIZATION

Article 1

Section 1. The Medical and Surgical Staff of the Knoxville General Hospital shall consist of physicians and surgeons who are appointed by the Director of Public Welfare upon recommendation of the Hospital Advisory Board, to serve the hospital in any capacity pertaining to the medical, surgical, laboratory and scientific departments of the hospital.

The Dental Staff of the hospital shall consist of dentists who are appointed by the Director of Public Welfare upon recommendations of the Hospital Advisory Board to serve the hospital in any capacity pertaining to dental service.

The division of the staff shall be: The Consulting Staff, the Attending Staff, and the Courtesy Staff.

QUALIFICATIONS

Section 2. Appointees to the Medical and Surgical Staff of the Knoxville General Hospital shall be composed of graduates of medicine from a reputable medical college conferring the degree of Doctor of Medicine, licensed to practice medicine in the State of Tennessee, and who are members of the Knox County Medical Society.

THE CONSULTING STAFF

Section 3. The Consulting Staff shall consist of active practitioners of medicine who have attained recognized standing and experience in their respective fields, and who shall be assigned by the Executive Committee to the Consulting Staff.

The Consulting Staff shall have the same privileges as members of the Attending Staff in attendance at meetings and voting power.

THE ATTENDING STAFF

Section 4. The Attending Staff shall consist of active practitioners, competent in their respective fields, who shall be responsible for the professional and scientific policies of the institution, and who shall be organized into the various clinical divisions insofar as practical, in order to

Dr. Bert W. Caldwell, executive secretary, American Hospital Association, aided in the revision of the rules and regulations of the staff of the Knoxville General Hospital, which are reproduced herewith.

Dr. M. T. MacEachern, American College of Surgeons, to whom a copy of the rules was shown, said: "I am glad to know you are publishing these by-laws, for I am sure they will be of interest to other institutions. I have reviewed the material and find it very complete and excellent in every way with the exception of adjourning the staff meetings for the three summer months. I suppose this is considered almost essential because of the heat. Inasmuch as deaths and other conditions which should be discussed occur at all times, some provision should be made for checking over the work, either through a meeting of the executive committee or the regular staff, even though poorly attended."

Dr. Eugene B. Elder is superintendent of the Knoxville General Hospital.

promote professional efficiency and provide for professional care of all patients applying to the hospital for medical treatment.

The Attending Staff shall be made up of the following departments and such other branches or subdivisions as may be determined by the Executive Committee of the Staff:

First—Department of Surgery.

- (a) General Surgery.
- (b) Orthopedics.
- (c) Urology.
- (d) Anesthesia.

Second—Department of Internal Medicine.

- (a) General Medicine.
- (b) Pediatrics.
- (c) Dermatology.
- (d) Neuro-psychiatry.

Third—Head Specialties.

- (a) Oto-laryngology.
- (b) Ophthalmology.

Fourth—Department of Obstetrics and

Gynecology.

- (a) Obstetrics.
- (b) Gynecology.

Fifth—Department of Laboratories.

- (a) Radiology.
- (b) Pathology.

Sixth—Department of Dentistry.

THE COURTESY STAFF

Section 5. The Courtesy Staff shall be allowed the privileges of the hospital subject to its rules and regulations, and shall consist of active practitioners who are qualified by training and experience to give competent care to their private patients in the hospital, who are legally licensed to practice in Tennessee, and who conform to and abide by the rules and regulations of the Knoxville General Hospital.

APPOINTMENTS

Section 6. Appointments to the Consulting and Attending Staffs shall be for the calendar year for which made.

OFFICERS OF THE STAFF

Section 7. Officers of the Staff shall be a Chief of Staff, Vice-Chief of Staff, and Secretary.

DUTIES OF THE OFFICERS

Section 8. The Chief of Staff shall act as an executive and presiding officer of the Staff. He shall appoint the executive and all other committees, except as otherwise provided, and shall be a member and Chairman of the Executive Committee and an ex-officio member of all other committees.

The Vice-Chief of Staff shall perform the duties of the Chief in his absence. When the Chief and Vice-Chief are absent, a temporary Chairman shall be elected by the Staff members present.

The Secretary shall keep a proper record of all Staff meetings, together with a record of all members of the Staff present. He shall transmit to the Director of Public Welfare, whenever requested by him, a copy of the proceedings of any Staff meeting. He shall notify all officers of the Staff of their election and all members of the committees and all chairmen of their appointments; and shall send them the names of all their associates on the committee and the purpose for which the committee was appointed. He shall notify all members of each regular or special meeting of the Staff at least two days before the appointed time, stating in the notices for any special meeting the nature of the business for which the meeting has been called.

ELECTION OF OFFICERS

Section 9. The Chief, Vice-Chief, and Secretary shall be elected from the Consulting and Attending Staffs at the annual meeting of the Staff on the second Friday night in January at 8 o'clock at the Knoxville General Hospital, and shall hold office until the next annual meeting, or

until their successors have been elected and entered upon the duties of their office. Any vacancies which may occur shall be filled by election at the next regular meeting of the Staff, and the officer or member so elected shall hold office until the next annual election. Election shall be by ballot and a majority of those present shall be necessary for election. If there be more than two candidates for the same office and no candidate received a majority on the first ballot, the candidate receiving the lowest number of votes shall be dropped for the second ballot and until a candidate receives a majority of all members present.

MEETING AND QUORUM

Section 10. All meetings shall be held at the Knoxville General Hospital.

At any meeting of the Staff, one-third of its members shall constitute a quorum. In any meeting of the Executive Committee, or other committees, a majority of the committee shall constitute a quorum.

ELIGIBILITY TO VOTE

Section 11. All members of the Consulting and Attending Staffs may vote on elections of Staff officers and on any measure coming before the Staff.

Article 2

EXECUTIVE COMMITTEE

Section 1. The Executive Committee shall consist of the Chief of Staff as Chairman, the Superintendent of the Hospital as Secretary and ex-officio member, and six members of the Staff, one from each of the professional departmental services of the hospital. The Superintendent shall keep the minutes and records.

Section 2. The Executive Committee shall meet in regular session once each month. Special meetings may be held on call of the Chairman, two members of the Committee, or of the Superintendent when it shall be necessary to give attention to matters of importance to the hospital.

DUTIES OF EXECUTIVE COMMITTEE

1. The Executive Committee shall have authority, supervision, and executive control over the medical and scientific operation of the hospital, and shall determine the number and title of services or sections, and make assignments to the various services and sections.

2. To act in an advisory capacity to the Superintendent in any questions pertaining to medical and scientific services in the hospital.

3. To represent the Consulting and Attending Staffs in medical and scientific matters requiring immediate attention.

4. To promote the full utilization of all available facilities of the hospital for the study, diagnosis, and treatment of patients.

5. To cooperate with the Superintendent in securing proper execution of the approved medical policies of the hospital and the observance of all rules and regulations related thereto.

6. To recommend to the Staff for cause the reprimand or dismissal of any member of the Staff. The Staff, after considering the recommendation of the Executive Committee, may reprimand or remove from the Staff the accused, all subject to the approval of the Director of Public Welfare. Before such reprimand or dismissal is recommended, the accused shall have the right to appear before and be heard by the Staff.

7. To recommend to the Hospital Advisory Board the number of physicians needed to staff the several departments of the hospital.

Features of Staff Rules, Knoxville General Hospital

Staff appointments are for the calendar year for which made.

Consulting and attending staff members have vote.

Superintendent of hospital is secretary and ex officio member of the executive committee of the staff.

Any staff member failing to attend meetings for three consecutive times and at least five meetings during the year shall be automatically dropped.

Special staff meetings may be called by chief of staff, superintendent or executive committee.

No rule shall be so construed as to give staff any control whatsoever over business management of hospital.

In all cases of disputed authority or uncertainty as to meaning of rules, the decision of the superintendent shall be operative until an interpretation shall be made by the director of public welfare.

8. To furnish to the Hospital Advisory Board the attendance record of all members of the Consulting and Attending Staffs for the current year.

COMMITTEES

Section 3. The Chief of Staff shall appoint committees as follows:

(a) *Committee on Interns and Resident Physicians.*

The Committee on Interns shall consist of three members, two members of which shall be the Superintendent of the hospital and the Chief of Staff, who shall provide adequate and systematic opportunity for medical instructions to interns and resident physicians who may be in training in the hospital. It shall be the duty of the Committee to consider and report on all matters relating to the intern service, to see that in instructions to interns the standards required by the hospital are maintained, and to make recommendations to the Director of Public Welfare for appointment of interns.

(b) *Committee on Monthly Staff Conference.*

The Committee on Monthly Staff Conferences shall consist of three members, or more, whose duty it shall be to prepare the agenda for the meeting, according to the following outline:

(1) Analysis of work.

Discussion of patients discharged since last meeting, with special consideration of agreement of diagnosis, consultations held, infections occurring in hospital, deaths and unimproved.

(2) Case reports of patients in the hospital.

(3) Case reports of patients discharged from hospital.

(4) Reports of the diagnostic and therapeutic departments.

(5) Considerations and recommendations for the improving of the professional services of the hospital.

(c) *Committee on Records.*

The Committee on Records shall consist of three members, whose duty it shall be to supervise and appraise case records by making sufficient investigation to determine that records are properly kept.

(d) *Training School Committee.*

The Committee on Training School shall consist of three members, whose duty it shall be to advise and cooperate with the Superintendent of the hospital and the Superintendent of Nurses in all matters pertaining to nursing education and service in the hospital, particularly the provision of adequate and systematic medical instruction to pupil nurses.

Article 3

MEETINGS

Monthly Staff Conference

Section 1. The Staff shall hold meetings in the hospital regularly once each month, on the first Friday, at 7:30 P. M., for the purpose of transacting general business and analyzing the clinical work of the hospital. Meetings for the months of July, August and September may be omitted. The order of business shall be as follows:

1. Calling meeting to order.
2. Roll call.
3. Reading and disposal of minutes of last meeting.
4. Business arising out of minutes.
5. Reports of Committees.
6. Presentation of clinical records.
7. Demonstration of specimens.
8. Suggestions for the improvement of the efficiency of the hospital.

Each member of the regular Staff is expected to attend two-thirds of the meetings during the year. Any member of the Staff failing to attend its regular meetings for three consecutive meetings, and at least five meetings during the year, without sufficient reason, shall be automatically dropped from the Staff.

SPECIAL MEETINGS

Section 2. Special meetings may be called at the request of the chief of Staff, Superintendent, or Executive Committee. Notice of regular or special meetings shall be posted in the hospital and mailed to the members of the Staff at least two days before any meeting and shall state the



purpose for which the meeting is called. In case of extreme emergency arising, the Chief, in consultation with the Executive Committee, may call special meetings without such two days' notice. At any special meeting only the business for which the meeting is called shall be considered.

Section 3. All meetings of the Staff shall be conducted according to Robert's Rules of Order, so far as there is no conflict with the rules herein.

Article 4

OTHER STAFF RULES

Section 1. The doctor attending the patient shall be held responsible for a complete case record promptly written as provided by the standard forms of the hospital.

Section 2. Service to the indigent patients of the city is the first and major duty of the Knoxville General Hospital, and any member of the Staff found guilty of inattention or neglect of duty in giving satisfactory service shall be subject to immediate removal from the Staff.

Section 3. Operations by courtesy will not be permitted, except under exceptional circumstances, in which event permission must be secured from the Chief of Staff.

Section 4. No rule shall be so construed as to give the Medical Staff any control whatever over the business management of the hospital.

Section 5. The Interns will, insofar as possible, obtain the history and record of the physical findings. The attending doctor shall review and verify these findings and amplify them as necessary. He shall attest to the accuracy by attaching his signature thereto.

Section 6. The surgeon shall be held responsible for a complete description of technique of operative procedure and findings in all cases, whether minor or major. This report shall be written up immediately at the conclusion of the operation.

Progress notes shall be written on the record by the house doctor or intern, subject to the approval of the attending physician. All orders by the attending doctor shall be in writing, and when received over the telephone shall be given only to the intern or a supervising nurse who shall immediately record it in the usual way, to be initialed later by the attending doctor. Upon discharge of the patient from the hospital, the attending doctor shall record fully the condition of the patient and the final diagnosis. He shall also record an order for the discharge of the patient or, in case of death, he shall make record of the cause of death.

Section 7. All records must be completed by the house doctor or intern, subject to approval of the attending physician. All records incomplete and not signed before the discharge of the patient shall be reported at the regular staff conference.

Article 5

OUT-PATIENT DEPARTMENT

Section 1. Those in charge of the Out-Patient Department shall be regularly appointed members of the Staff of the Knoxville General Hospital, and shall be associated in the General Hospital with the respective services to which they are assigned in the Out-Patient Department. Where vacancies occur on the services within the hospital, preference in such assignments shall be given to those rendering satisfactory service in the Out-Patient Department.

Article 6

INTERNS

Section 1. There shall be appointed by the Director of Public Welfare, upon recommendation of the Chief of Staff and the Superintendent, Interns having the usual and necessary qualifications.

Section 2. The Interns shall be under the immediate direction of the Superintendent, to whom they shall be responsible for the satisfactory performance of the duties of Interns and their personal conduct.

Section 3. The Superintendent shall, on recommendation of the Chief Resident, regulate the periods when the Interns are on duty to conform to the professional needs of the hospital. The Interns shall not be absent from the hospital more than six hours in any twenty-four hour period. No Intern shall absent himself from the hospital for any period of time without having another Intern cover his service, and he must notify the telephone operator when he leaves, when he expects to return, where he may be reached by telephone, and who is to be responsible for his service while he is out.

Section 4. No Intern shall engage in private practice or other business which will take him away from the hospital during his term of service, and shall not assist any physician in his private practice outside of the hospital.

Section 5. No Intern shall accept any pecuniary compensation, other than that given by the Hospital, from patients or their friends or relatives, or physicians, unless by permission of the Superintendent.

Section 6. It shall be the duty of the Intern to take all histories of patients entering the hospital, excepting in those cases where the patient or physician objects. In that case it shall be the duty of the physician in charge to obtain such history.

Section 7. The Intern shall be in charge of all accident cases when first brought to the Hospital, and until the physician on service or the private physician, arrives.

Section 8. The Intern shall visit each patient in the Hospital at least twice daily.

Section 9. He shall give such professional care to the patient as the attending physician shall direct.

Section 10. In emergencies the Intern shall have full charge of the case in the absence of the attending physician, and if the attending physician is not available, he may call in another physician, if in the judgment of the Intern and the Superintendent it seems best.

Section 11. The Intern shall do such emergency laboratory work as is required in the absence of the regular laboratory force.

Section 12. The Intern shall act as assistant at operations upon patients in the Hospital when requested by the operator.

Section 13. The Intern shall act as Anesthetist at operations in the Hospital whenever the regular anesthetist is absent or unable to give the anesthetic.

Section 14. There must be four Interns, exclusive of the man on Oral Surgery, on duty in the Hospital at all hours.

Section 15. In all cases where the Intern is in doubt regarding a patient's condition, or anything else pertaining to the Hospital, he shall consult the resident at once. Complications, elevations in t.p.r., hemorrhage, severe pain, unconsciousness, etc., should be reported at once to the Resident.

Section 16. Interns shall discharge patients only on order of the Attending Physician.

Section 17. In the absence of the Chief Resident, the Intern on Surgery shall act as Chief Resident. Interns on Surgery and Gynecology shall not be absent at the same time.

Section 18. Interns must make rounds with their respective Staff members, emergencies permitting.

Section 19. A tentative diagnosis must be put on each chart at the time of admission, and the patient assigned to the proper service.

Section 20. Consultation blanks are to be used for consultations or reference.

Section 21. X-ray requests are to be made out by the Intern on Service and not the nurses. All patients, both city and private cases, are to have routine blood and urine examinations as soon after admission as possible.

Section 22. No house surgeon or Intern shall absent himself from duty or from the premises of the Knoxville General Hospital without giving due and timely notice, and not then unless it be without detriment to the service.

Article 7

ADMISSION OF PATIENTS

Section 1. Only bona fide citizens of Knoxville except police cases who are sick, maimed or injured and who are not able to pay for hospital services shall be eligible for admission to the Knoxville General Hospital for free treatment. All patients applying for free admission shall be subject to such inquiry as may be necessary to determine their economic status, and when it is found that the applicant or his immediate relative is able to pay for hospital care and attention, then such applicant shall be ineligible for admission to the free service.

If patient gains admission to the hospital through misrepresentation or fraud and is not eligible to its benefits, the Superintendent shall take such steps as may be necessary to require payment, or have such patient removed from the hospital.

Section 2. Patients for major operations must be in the hospital not later than 9 P. M. of the day preceding the operation, excepting those who are admitted for emergency operations. Minor cases shall be in the hospital at least one hour before operation.

Section 3. No patient shall be admitted to the hospital without a provisional diagnosis except in case of emergency, when a provisional diagnosis shall be given as soon as possible after admission.

Section 4. Members of the Staff are expected to give such information that will enable the hospital administration to protect the other patients from those who



are suffering from contagious diseases or other conditions which might be detrimental to the physical welfare of the other patients in the same ward.

Section 5. The operating room of the hospital will not regularly be opened before 8 A. M. nor later than 5 P. M. for each week day except for known emergencies. The operating room shall not be opened on Sunday or holidays except for known emergencies. Emergencies shall at all times take precedence over regular assignments.

Section 6. The Hospital shall not admit patients having insanity, delirium tremens, acute alcoholism or mental diseases in which the welfare of the hospital patients may be jeopardized, according to the judgment of the hospital management, except when suitable quarters are available and a suitable attendant is furnished.

Since the bed capacity of the Hospital is limited, chronic cases which will not yield to treatment shall not be admitted, as the Hospital shall give preference to acute conditions which can be relieved by treatment or by operation.

Article 8

GENERAL RULES AND REGULATIONS

Section 1. No operative interference shall be allowed in any type of abortion case without the following: (a) Consultation with a member of the attending staff approved by the Superintendent, (b) the affirmative opinion of the consultant as to the necessity for operative interference, (c) a statement of indications recorded on the patient's chart before any procedure is undertaken.

Section 2. In no case except in dire emergency shall major operations be done prior to examination of blood and urine.

Section 3. All tissues removed at operations shall be the property of the hospital and be examined by a competent pathologist. The report shall form a part of the patient's case record.

Section 4. As far as possible, the use of proprietary drugs shall be avoided. When they are considered necessary by the physician, they shall be obtained and a special charge made.

Section 5. Every attending physician or his assistant shall see all his patients as often as necessary. A record of such visits shall be kept by the nurse in charge of the ward, and in the event of neglect of this rule, the Executive Committee of the staff shall call the physician's attention to his neglect and may, if necessary, report it to the staff.

Section 6. Consultations are desirable and shall be held when necessary. In the case of free or part pay patients, any physician shall give his services free in consultation, on request of the attending physician, who shall also render free service. The consultant shall write his findings and recommendations, and this report shall form a part of the patient's record.

Section 7. The members of the staff shall see that patients are discharged as soon as their condition warrants. On discharge of a patient the physician shall see that his history is properly written and shall write his final diagnosis and the result of treatment and sign the record of history.

Section 8. At the monthly meeting of the staff, the medical records office shall present a report showing patients discharged during the month, detail of patients unimproved or dead, and a report of hospital infections. These detailed reports shall be made in such a manner that the identity of the patient is not disclosed. The discussion of the work in the hospital

shall be based on this report from the medical records office. After these monthly meetings the secretary shall transmit to the superintendent, in writing, such reports and recommendations as the staff may wish to make to him or through him to the Director of Public Welfare.

Section 9. Routine orders shall be worked out by the staff whenever possible, so as to facilitate the work of the hospital. These routine orders shall become effective when so ordered by the Superintendent.

Section 10. The practice of fee-division is prohibited. No physician practicing in this hospital shall give to, or receive from, another physician any part of a fee received from a patient. It is recommended that physicians render all accounts separately and send individual receipts for payment.

Section 11. Diagnostic and therapeutic facilities, under competent medical supervision, shall be available for the study, diagnosis, and treatment of diseases. These to include at least (a) a clinical laboratory providing chemical, bacteriological, serological, and pathological services; (b) an X-ray department.

Article 9

SUPERINTENDENT

Section 1. Subject to the direction and control of the Director of Public Welfare, the management of the hospital shall be vested in the Superintendent.

Section 2. The Superintendent, when acting within the scope of authority conferred, shall, in all matters pertaining to hospital administration, directly represent the Director of Public Welfare, and shall be responsible to the Director of Public Welfare alone for the proper performance of the duties of Superintendent.

Section 3. The Superintendent shall see that all proper directions for the nursing and care of patients given by the attending and assisting physicians and surgeons are carried out by the nursing staff.

Section 4. The Superintendent shall take charge of all monies and other property not in use belonging to the patients, and shall keep an account of the same and return the same to patients upon their leaving the hospital.

Section 5. The Superintendent shall have made a record of the name, age, birthplace, nearest relatives if any, and disease of every patient admitted to the hospital; the date of admission and upon what terms; the date of discharge and what conditions, and all other particulars which may be required.

Section 6. The Superintendent shall render weekly accounts to patients or to those responsible for them, and receive payment for the same, and shall pay all monies received to the City Treasurer.

Section 7. The Superintendent shall engage and have power to dismiss all employees, including probationers and nurses,

subject to the approval of the Director of Public Welfare.

Section 8. Upon the death of any patient in the hospital, the Superintendent shall see that the body is removed as soon as convenient to the mortuary, and shall take such steps as may be reasonably possible to notify the relative of the deceased or other person interested and secure from them their choice of undertaker, and shall enter the name of the patient and the time of decease in a register kept for that purpose, and according to the statutes and regulations provided therefor.

Section 9. In all cases of disputed authority or uncertainty as to the meaning of these rules and regulations or any other rules or by-laws for the regulation of the hospital, the decision of the Superintendent shall be operative until an interpretation and ruling shall be made by the Director of Public Welfare.

Section 10. The Superintendent shall cause to be kept in the office of the hospital or other convenient place a book for all members of the staff in which they shall register in and out of the hospital.

Section 11. The superintendent shall perform such other duties as the Director of Public Welfare shall from time to time direct.

NEW TYPE GAS RANGES

To meet the necessity for cost cutting equipment, the Standard Gas Equipment Corporation, New York put on the market a year ago a line of Vulcan Heavy Duty Gas Ranges, broilers, and other equipment. Improvements included oven insulation, automatic heat control, better heat distribution, and more efficient use of gas. Recently another line was announced, the Junior Heavy Duty Line, which embodies the improvements of the regular line, but is smaller in size.

According to the manufacturer, this new equipment accomplishes the following:

Reduces heat losses and gas consumption in oven cooking because of thick insulation.

Makes more effective use of oven heat due to an improved flue system. Ovens bake and roast equally well.

Overheated ovens and resultant food shrinkage and waste of gas are prevented by means of an automatic oven heat control. Uniform results are assured because of exact temperature control.

Top cooking is made more efficient because heat from one burner is spread under entire "All-Hot-Top." Frequently one range will do the work of two of open top design. The aerated burner has three separately controlled rings. All three rings heat the top quickly, then one keeps it hot economically.

Reduces labor costs because more work is done by the kitchen force due to more comfortable working conditions. The ranges require less watching. The smooth front of the range is kept clean more easily.

The fuel and food saving advantages of insulation and heat control have been applied also to bake ovens and deep fat fryers.

The manufacturers will be glad to supply complete descriptive literature on application.

SEEKS R. F. C. FUNDS

The state of Arkansas, according to recent reports, is attempting to borrow from the Reconstruction Finance Corporation to complete the building program of the Benton State Hospital at Benton.



The John M. Peters House for Rhode Island Hospital Interns



The John M. Peters House; portion of hospital group in background.

THE building for staff use and interns' residence at the Rhode Island Hospital was opened April 22, 1931, with appropriate ceremonies by United States Senator Jesse H. Metcalf, president of the trustees of the hospital, donor of the building. The official designation of the building is the John M. Peters House, a tribute to Dr. Peters, who has been superintendent of the institution for many years.

The building is a four-story structure of red brick and limestone of a simple Georgian style, built into a bank at right angles to and on the south end of the main group, so that on the quadrangle side the building appears on the westerly end to be but three stories high.

The completion of the building solved a long standing problem of proper housing of interns, and while it will accommodate 38 men in single rooms, it can, by the addition of another story, accommodate 19 more.

The third and fourth floors are given up to bedrooms, baths, lavatories and toilet rooms; the end rooms are en suite with a bath between for the use of the resident physicians.

All bedrooms are finished in dark maple; the beds are of same material, with box springs and mattresses, and in addition, contains chiffonier, study desk, an overstuffed chair, an occasional chair with rush bottom seat, also a hanging mirror, bridge lamp, large closet, telephone stand, bedside light and rugs.

It was deemed prudent not to have a lavatory in each of the single rooms. Floors in these rooms are of Jaspe linoleum. There are no ceiling lights.

The solaria at the east end of the

three upper floors are used as sitting rooms and are heated.

The second or main floor has two large rooms, each approximately 23 by 35 feet; the one at the east is the medical library, with high bookcases, and the one in the center, the lounge, so-called. Both rooms are finished in fumed white oak, the lounge in wide panels full to the beamed ceiling. Over the fireplace in a broad panel is a portrait of Dr. John M. Peters. The floors of these two rooms are of rubber tile, covered with large Oriental rugs, and the rooms are beautifully furnished (as is the whole building) by H. N.



JOHN M. PETERS, M. D.

Veteran superintendent of Rhode Island General Hospital, Providence, is among the few administrators in whose honor units of their institutions have been named.

Campbell, the oldest living trustee of the hospital.

On the main floor are several small consulting rooms for the members of the staff, coat room, toilet room, smoking room, two study rooms off the library, and an office for the matron.

Because of the location of and the grades about this building, there is an entrance from grade on the north side directly into the lounge at the second floor level, and there is also another entrance at the west staircase.

On the first or ground floor the entrance faces the south and looks out onto a large parking space where nearly 100 cars can be cared for. This parking space is exclusively for the staff.

On the first floor there is a billiard room, an amphitheater or lecture hall seating about 100 persons. Facing the seats in this hall there is an alcove which accommodates a stage. Slides or moving pictures can be shown. Leading from the lecture room are dressing and preparation rooms.

On this floor there is also a squash court with showers and toilets, a waiting room for patients, a kitchen for the interns, trunk rooms and storerooms.

The house is connected to the ground floor of the south wing of the main building by a tunnel, and through another smaller tunnel connections are made to the power house for steam, hot water and electricity.

The stairways, all toilets and all rooms and corridors in the first floor



View of the magnificent lounge.

are finished five feet high in glazed brick tile of varied hues.

The walls throughout, except the library and lounge, and above the tile, are in colored stucco with hard, smooth finish and a permanent color, in plain white, hard plaster. In the amphitheater and the squash court a macoustic plaster has been found very satisfactory.

The roof having no air space (the slab will be the future additional floor), was insulated with .2 inches of an insulating material.

The door and window trim and base, with the exception of the lounge and library, are of pressed steel, painted a light sage green, the doors are of birch, stained a tobacco brown.

In the toilet rooms the floors and base are of terrazzo subdivided with brass inserts. The floor and base of solarium are of quarry tile.

The building is of fireproof con-

struction, and all staircases are of steel with blue stone treads.

The center staircase runs from first to second floor only, and is for the staff, who will use the south door after parking their cars, ascend to the next floor, register "in" on the electric registration board at the matron's desk, deposit their outer clothing in the locker room, and proceed with their duties.

Doctors' call system and telephones are placed at strategic locations, as well as pay telephone stations.

Radio connections are provided in each solarium and in the lounge.

The building contains approximately 220,000 cubic feet and cost, not including the parking space, certain outside walks, stairs from one level to the higher, landscaping, etc., about 87 cents per cubic foot, including furnishings.

Meeting the Cost of Sickness

THE PURCHASE OF MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

By Pierce Williams, 320 pages, \$3.00.

Published by National Bureau of Economic Research, Inc., New York, N. Y., 1932.

Pierce Williams of the research staff of the National Bureau of Economic Research, Inc., has made a noteworthy contribution to the growing literature on the general subject of meeting the costs of medical care. His book bearing the title "The Purchase of Medical Care Through Fixed Periodic Payment" has recently been published. The study which resulted in the book was made at the

invitation of the Committee on the Costs of Medical Care.

Payment for medical service other than by the patient himself may be provided by insurance, the costs of which the patient himself may bear entirely, in part or not at all. Medical service for employees may also be provided by the employer, the expense entailed being added to his production costs.

Before presenting the plans operative in several sections of this country the author discusses the American Campaign for Compulsory Sickness Insurance. This campaign was waged chiefly between the years 1915 to 1920. It had no results in legislation.

Mr. Williams then presents the plans in use in the lumber and mining industries in Washington, Oregon and California, the metal industries of the Rocky Mountain States, and the mining industries in several other regions. A chapter is devoted for fixed payment medical service for railroad employees. Several chapters treat of the various means of provided medical care by group clinics, community hospitals and through the agencies of the mutual benefit association, through trade unions and by means of commercial accident and health insurance companies.

Of special interest to the readers of HOSPITAL MANAGEMENT are those sections of the book related to the provision of and payment for hospital care under the several plans. Two plans for providing medical care for injured workmen in the lumber and mining industries of Washington are in operation. Under one of these plans known as the state plan, premiums are paid by employees and employers into the state medical aid fund. If injured, a workman may choose his physician and hospital. The employer provides transportation to the place of treatment, but all costs of treatment are paid for out of the state medical aid fund. Under the other plan the employer, with the consent of 50 per cent of his employees, may contract for medical and hospital service. Most of this contract hospital medical service in the state of Washington is provided by a relatively small number of hospital associations or clinics, though some community hospitals do some of this work. Most of these hospitals are owned or controlled by physicians. The actual medical service is performed by medical practitioners who may be remunerated on a profit sharing basis, a fixed salary, or on a fee schedule covering the various types of service rendered. There is certain State supervision of this service.

In the metal mining industries of the Rocky Mountain region employees may secure medical and hospital care for injuries and diseases not covered by state workmen's compensation laws. Premiums are paid by deductions from wages. Some of the larger companies maintain their own hospitals, but most of them contract with independent hospitals.

In the coal and metal mining areas of the Middle West and Pennsylvania variations of the contract system obtain as well as company-owned and operated hospitals.

Employees of a number of leading railroad systems of the country have organized their own hospital associations through which they obtain med-

ical, surgical and hospital care. Most of the costs are borne by the employees through deductions from wages, though the Associations receive some money from the railroad companies in payment of care of employees injured in the line of duty. Some of these associations own and operate their own hospitals, title to which is usually held by the railroad company.

In another chapter is presented various schemes in use in several communities by means of which groups of individuals purchase medical and hospital service through fixed periodic payment. Among these are the Thompson Benefit Association for Hospital Service in Brattleboro (Vt.), the New Bedford medical insurance plan, Baylor University Hospital plan, the Grinnell, Iowa, Hospital plan, etc.

The book is well worth reading by any person interested in the place of a hospital in the various schemes by which medical service can be purchased by other means than the prevalent, individualistic arrangement between patient and hospital.—JOHN E. RANSOM.

Be Sure Your Library Is Listed Here

By Catherine Poyas Walker,
Chairman, A. L. A. Committee on
Hospital Libraries

Information is desired for the Directory of Hospital Librarians and the Directory of Hospital Libraries to be included in the new "Bibliotherapy—A Manual for Hospital Librarians," now being compiled by the American Library Association Committee on Hospital Libraries. Hospital and medical librarians, state, county and city hospital library supervisors, and librarians for the blind are requested to co-operate by sending information for use in these directories to the committee chairman at 1645 Peachtree NW, Atlanta, Ga.

The following is indicative of what is desired, though any pertinent or special information may be of use, and suggested topics will be considered for inclusion.

Please state position in library, whether a library school graduate, if a volunteer or paid worker, and if in charge of both medical and patients' libraries.

Statistics and full information concerning the hospital are needed, including whether there are medical students and student nurses. A copy of the legislation authorizing the hospital library or the hospital library supervisor is requested.

These Hospitals Lead Their States In Obstetrical Service

HERE is a compilation of the hospitals which reported to the American Medical Association the largest number of births for the year 1931. Note the number of institutions conducted by units of government, such as county, city, state university, also the showing of maternity hospitals.

State	Hospital	City	Babies
Alabama	Hillman	Birmingham	1,138
Arizona	St. Joseph's	Phoenix	441
Arkansas	St. Vincent	Little Rock	303
California	Los Angeles General	Los Angeles	1,805
Colorado	Denver General	Denver	630
Connecticut	Hartford	Hartford	1,726
Delaware	Homeopathic	Wilmington	435
District of Columbia	Sibley	Washington	1,648
Florida	St. Vincent	Jacksonville	446
Georgia	Grady (Colored)	Atlanta	1,403
Idaho	L. D. S.	Idaho Falls	358
Illinois	Cook County	Chicago	3,536
Indiana	Coleman	Indianapolis	1,193
Iowa	Methodist	Des Moines	713
Kansas	St. Francis	Wichita	429
Kentucky	City	Louisville	968
Louisiana	Charity	New Orleans	2,100
Maine	Maine Eye and Ear Infirmary	Portland	323
Maryland	Johns Hopkins	Baltimore	1,072
Massachusetts	Boston Lying-In	Boston	2,763
Michigan	Providence	Detroit	2,236
Minnesota	Ancker	St. Paul	1,146
Mississippi	Southern Mississippi Charity	Laurel	355
Missouri	St. Louis City	St. Louis	2,077
Montana	Columbus	Great Falls	456
Nebraska	Creighton Memorial	Omaha	529
Nevada	St. Mary's	Reno	93
New Hampshire	Elliot Community	Keene	231
New Jersey	Jersey City	Jersey City	1,779
New Mexico	St. Joseph's Sanitarium	Albuquerque	168
New York	Lying-In	New York City	3,608
North Carolina	Walker Memorial	Wilmington	480
North Dakota	St. John's	Fargo	495
Ohio	Maternity	Cleveland	2,315
Oklahoma	St. Anthony	Oklahoma City	943
Oregon	Emanuel	Portland	970
Pennsylvania	Elizabeth Steele Magee	Pittsburgh	2,363
Rhode Island	Providence Lying-In	Providence	2,363
South Carolina	Roper	Charleston	514
South Dakota	St. Luke's	Aberdeen	359
Tennessee	Memphis General	Memphis	923
Texas	Memorial	Houston	1,141
Utah	L. D. S.	Salt Lake City	1,091
Vermont	Mary Fletcher	Burlington	277
Virginia	Norfolk Protestant	Norfolk	486
Washington	Providence	Seattle	890
West Virginia	Ohio Valley General	Wheeling	363
Wisconsin	St. Joseph's	Milwaukee	967
Wyoming	Memorial	Cheyenne	248

State if the library is for patients only, or if it is also medical, or the two are separate; include library staff by name—untrained helpers by numbers; mention types of readers served—doctors, medical students, nurses, student nurses, for professional or recreational reading or both; patients—men, women, children,—T. B., general, psychiatric, orthopedic, etc.; statistics—volumes, periodicals, circulation in library and wards; appropriations—book fund; procedure of loans to patients with contagious diseases; observations on therapeutic value.

Hospitals with book collections, but without librarians, are requested to

send the number of books available to their patients.

HOSPITAL FIELD DAY

Local newspapers paid a high tribute to the Punxsutawney, Pa., Hospital and to Col. L. C. Trimble, superintendent, for a unique and highly successful field day. A parade, games and exhibitions, poster content, ambulance run and hospital ball were among the many features.

SPECIAL NURSING

Butterworth Hospital, Grand Rapids, Mich., some time ago advised its staff members that it would furnish special nursing service to needy patients requiring this service, without cost. The hospital reserved the right to decide to whom this service was to be given and for how long.

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superintendent's own institution on his return. Again, in order to refresh his mind on certain points in connection with the recommendations he made to the surveyed institution, this man went over details and departmental policies in his own hospital with which he had practically no contact for some years, and found that in some instances certain matters had been allowed to vary and change until today they hardly resembled the set-up which had been made for a given department.

The point of this is that it pays to make a check-up on almost any institution or any department annually or perhaps less frequently, just to prevent the tendency to drift away from rigid technique and schedules and to introduce short cuts which, while working excellently under one set of conditions, will never do under another.

Veteran administrators occasionally speak of the value of a self-survey, but many of them actually do not appreciate its real worth until they have occasion to check up on some detail in the operation of the institution and discover that through carelessness or for some other reason changes have been allowed to be introduced, small variations when considered singly, which are radical in their scope when considered as a whole over a period of years.

Why Change Superintendents When Hospital Is Enlarged?

When important additions are made to a hospital plant or when an entirely new building project is agreed on or completed, boards of trustees sometimes seem to think that the man or woman who so expertly managed the institution in the past is not competent to manage it under the new conditions. Just why this idea should be arrived at or even considered is difficult to fathom, for, generally speaking, the hospital will have the same medical staff, the same personnel, the same board and will serve the same community, although its personnel may be increased to serve the larger numbers its new plant will accommodate.

A study of the effect of changing a superintendent just because a new hospital plant has been decided on, or completed, has never been made, but there are frequent instances where this change eventually resulted in inconvenience, trouble, and in some instances in serious handicaps to the institution.

The only reason why the change is made, in most cases, is that "Our new hospital will be much larger; we must have a person of broader viewpoint and experience as superintendent." Forgotten is the long record of expert management, of careful attention to all phases of the hospital's welfare and development; forgotten are the struggles of the early days or the long hours of hard work and worry that the superintendent regularly gave that some problem of considerable scope might be satisfactorily solved. Forgotten are the many personal friendships, of inestimable good will to the hospital, enjoyed by the old superintendent and his or her chief associates. The board wants a new executive for the new institution, and so the old superintendent must go.

It is manifestly unfair to discharge a faithful and heretofore competent superintendent just because of a new building unless proper arrangements for the individual are provided. It is just as unfair, in many instances, to the hospital for the board to deprive the institution not only of the executive ability of the old superintendent, but his or her special knowledge of the staff, of the board, of influential individuals in the community, and of the

Self-Survey Easy Way To Keep Hospital Up-to-Date

An experienced superintendent who recently was commissioned to make a thorough study of the operation of another institution said that one of the most stimulating results of the survey was the beneficial effect the study had on his own hospital. This man took for granted certain methods and routine in his own hospital, as he made recommendations in the other institution, and when he returned to check these methods he occasionally found that over a period of years changes gradually had been introduced and had spread, with the result that today's procedures, although regarded as strictly following the original schedules of the departments, actually differed widely.

Another type of beneficial result that followed this survey was the discovery of certain admirable practices in the institution visited, which were introduced into the

superintendent's skill, born of long experience, in developing teamwork among personnel, some of whom are not overfriendly with each other.

That the replacement of a faithful veteran superintendent with a newcomer as a new hospital plant is being occupied is not always wise is seen by the occasional series of changes that follow this move. The newcomer, blameless in every respect, comes to the hospital absolutely ignorant of board or staff likes and dislikes, or community problems, of the idiosyncrasies of influential people, of the traditions of the hospital. With this ignorance he or she may do something in perfectly good faith that will stir up enmities and bring open antagonism to the hospital at the very moment when, because of its new building and added financial burden, it needs all the friendship and good will that it can command.

All of this is not an argument that no old superintendent should be changed when a new building project is undertaken, but it is an argument on behalf of the veteran superintendent whose record proves that he or she amply merits a trial as the executive of the enlarged institution.

Sometimes Rate Cut Means More Taxes

A great deal has been said lately about the further utilization of existing hospital beds by governmental units even if the hospitals are controlled by non-government agencies, such as church, benevolent or other associations. A great deal also has been said about the advisability of reducing hospital rates.

Among the hospitals which have announced a reduction of rates in some instances throughout every department and room in the institution are a number of hospitals operated through taxation or receiving the major part of their income from taxation. One result of this announcement is to make the public in these communities wonder why the non-public hospitals have not also reduced rates.

The answer, of course, is clear to those in the field, but it is far from clear to the public. The public does not understand that the City or County Hospital will ask the taxing bodies for additional funds to cover operating losses, and that, in effect, the reduction of rates only means that the public will share a greater part of the burden of maintaining the institution. The non-public hospital, which must depend on receipts from patients, from donations from friends, and from earnings and income from endowment, if any, has no other recourse, and it cannot meet the competition of the city-owned or county-owned hospital in any reduction.

But the public only reads that one hospital has made a radical reduction in prices and that the other has not, and the hospital which has not made any reduction is subject to unfavorable speculation and to suspicion.

Instances of this kind have occurred and the trustees of the tax supported hospital have taken considerable credit to themselves as public benefactors. They, of course, are not public benefactors, for in effect they are encouraging the public to receive service below cost and part of the cost of this service must be paid through tax funds.

The non-public hospital which is in a community in which a situation like this exists has a difficult time. It might be accused of improper conduct if it attempts publicly to explain how the losses resulting from the re-

ductions of the other institution must be met. But the superintendent of a hospital in a town in which there is such a situation certainly should do everything in his or her power to make his own board of trustees understand just what such a reduction means.

Two Effects of Ousting Of Competent Superintendents

It is admitted that, generally speaking, there are many more nurses than opportunities for work for nurses. But suppose there were just about sufficient nurses to do the work required and that into the field would come a number of people without training or experience whose compelling motive was a desire to earn a living. And suppose that as these untrained people came, the real nurses were displaced. Two results would be noticed: In the first place, the standards of nursing would be perceptibly lowered, and in the second place, nurses' salaries would drop, because the nurses who were displaced, in many instances, driven by necessity, would be willing to work for less than customary.

This same situation, in a sense, is taking place among hospital superintendents. A number of experienced men and women are being driven from their positions by men and women without experience or intimate knowledge of the field. The latter are ousting the experienced superintendents because they themselves need work, and their influence or position in the community is such that the boards of hospitals cannot withstand their requests to be made superintendents.

The ousted superintendents, in turn, may seek a position elsewhere for a time, but finding no openings, will then bargain as to salary. In some instances another board will employ them at a lower salary, thus tending to set a lower standard of pay. Furthermore, as the percentage of untrained superintendents grows, the standards of management in the field are adversely affected.

In the case of the nurses such a state of affairs cannot exist, because state laws prescribe punishment for any persons attempting to practice nursing without meeting the legal qualifications. In the case of hospital superintendents, there are no legal qualifications, nor are there any other qualifications or standards of ability or experience which are generally accepted.

HOSPITAL MANAGEMENT has been discussing this subject frequently of late, and these remarks are occasioned by a number of experienced and interested superintendents who recently joined the army of the unemployed by virtue of their being replaced by an untrained and inexperienced person whose greatest qualification was that he had some influential friends and that he needed a job.

Thoughtful hospital superintendents, actively interested in the development of the field of hospital administration, consider this state of affairs a serious matter and they would like suggestions as to what might be done to make boards appreciative of the value of experience and ability in the management of a hospital. The situation also is of importance to associations, whose objects are further improvement of institutional service to the sick, because the backbone of such groups are the men and women who regard hospital service as their life work. These people naturally are much more interested in the programs of associations than persons who come into the hospital field simply because they need a job and plan to leave the field as quickly as possible.

COMMUNITY RELATIONS

Educational Campaign Brings Results Here

By ALICE TAYLOR

Superintendent, All Saints Episcopal Hospital, Fort Worth, Tex.

THE leaflets and other printed materials we have used in our direct mail advertising campaign may, or may not, have brought more patients to the hospital, but one thing it surely has done and that is, that it has brought about a feeling of co-operation between the hospital and the doctors who practice here.

It is not unusual for doctors in the surrounding territory to bring patients into the hospital and then call the consulting surgeon, whereas formerly the consulting surgeon was contacted first.

Another very noticeable result has been the greater ease with which we are making collections from patients, especially for the "extras." It is the exception rather than the rule to have to argue that this or that charge was understood to have been included in the room charge.

I believe that a campaign of this kind should not be started unless one has decided it would be continuous, persistent and regular. By constantly "advertising" over a long period of time there is a possibility of a general increase of business, because the hospital and its facilities will be more talked of, better known as to rates and facilities.

The letters are sent to all members of the Tarrant County Medical Society, friends of the hospital, all clergymen of our own denomination and some of those of other denominations that do not have a hospital of their own, outstanding business men, and insurance men and firms. The total mailing list is 500 names.

If hospitals could have the same number of patients now as they had a short time ago, I feel that we would have had a greater number, and consequently fewer empty beds. But some one has said that there is a "depression" on at the present time. I believe, however, that in comparison with other hospitals our average occupancy has been "as good as could be expected." And it has only been by "main strength and awkwardness" that we have managed to keep our expenses within our income.

I hope that the time will soon come

All Saints Hospital is one of the few hospitals which have grasped the importance of carrying on an educational effort over a long period in order to achieve desired results. This institution has been carrying on an educational program for over two years sending out letters, leaflets and other printed material each month, varying the form and in every instance utilizing attractive typography and interesting illustrations. Here are some comments on the results of this program.

when we can make more definite contacts with the public, acquainting them with hospitals and their facilities and offsetting some of the quackery that exists only through the fact that people will believe that which is advertised.

I have had a great many comments from people who are receiving our letters and pamphlets, all of them favorable. Some thank me for placing the rates and facilities in an understandable manner, and often doctors will ask for additional copies for some patient, or to replace a lost folder. It



has been an aid to doctors in their office in helping a patient figure about what the hospital bill will be.

I do believe that hospitals should have definite "advertising" programs, and that they should contact all persons they possibly can, by news items, pictures, parties and radio.

Pennsylvania Group Informs Public

The Hospital Association of Pennsylvania has launched an educational campaign to enlist the cooperation of the public in an effort to remedy the present plight of the institutions. An attractive booklet, entitled, "What's Happening to Hospitals?" is the first effort of the association and this has been widely distributed by members of the group and has received further publicity in hospital bulletins and in local newspapers.

The booklet is the work of an expert publicity director who is working under the supervision of the association and who has been supplied with detailed information concerning shrinkage in receipts and in endowment income, as well as expansion of demands for free and part-free service. All of this information, interpreted in an effective way, appears in the booklet, which should cause many people to get a new idea of current financial problems of hospitals.

CATHOLIC NURSES

At the 1932 business meeting of the National Catholic Federation of Nurses at St. Vincent's Hospital, New York City, the following officers were elected:

President, Mary La Rue, Milwaukee; vice-presidents, Alberta Hausmann, New York; Mary Graef, Denver; recording secretary, Emma Disette, Cleveland; corresponding secretary, Mary T. Dowling, New York; treasurer, Anna Weisenhorn, Quincy, Ill. Directors: Sister Mary Felice, New York; Sister M. Florina, Hammond, Ind.; Sister M. Robert, Elmira, N. Y.; Sister M. Therese, Chicago; Sister M. Victoria, Ashland, Wis.; Evelyn Donnelly, Brooklyn; Theresa B. Darr, Dayton, O.; Mary McCormick, Ogdensburg, N. Y.; Kathryn McGovern, Minneapolis; Loretta M. O'Connor, Los Angeles.

Among important resolutions passed was one to hold the 1933 convention in Chicago, and to incorporate the members of the International Catholic Federation of Nurses in the United States as the National Catholic Federation of Nurses preliminary to the international conference of Catholic nurses at Lourdes, in 1933.

Sister Mary Felice, superintendent, St. Vincent's Hospital, New York, was voted the honorary membership awarded annually for distinguished service to the Federation.

Articles for Your Local Press

Fill in names, facts, etc., indicated and send a copy of each article to every newspaper, weekly or daily, published in area from which patients come; also to club, church and other publications

Hospitals Busier, But Income Has Decreased

(Week of Sept. 19)

Hospitals are doing more business than ever, yet never in their history were they in such a poor financial condition, generally speaking. This contradictory statement was made by _____ (name) superintendent of _____ (name) Hospital, yesterday. The explanation is that more people seek hospital care than ever before and the percentage of those able to pay, which always was considerably smaller than the proportion of those paying in full, has decreased still further so the hospitals' income has fallen to a very low level. In 1931, for instance, according to the American Medical Association, there were nearly 50,000 more patients in hospitals every day than in 1929. The percentage of patients paying in full averages considerably less than 50 per cent, and it is estimated that 40 per cent is closer. That is, about six of every ten patients in a hospital pay less than cost, many of them paying nothing.

80,000 More Hospital Babies in '31 Than '29

(Week of Sept. 26)

That old song about "I remember, I remember the place where I was born," is rapidly going out of style, unless the modern singer is talking about hospitals. According to _____ (name), superintendent of _____ Hospital, last year 80,000 more babies were born in hospitals than in 1929. In 1931, the superintendent says, the hospitals reported to the American Medical Association that 708,889 babies were born in their maternity departments, while in 1929 the number of births reported was 621,896. So the baby that isn't born in a hospital these days is old-fashioned, and at the rate the stork is visiting hospitals, the home-born baby eventually will be a rarity. The local hospital reported _____ births in 1931 and _____ in 1929.

"Hospital Begins Where the Hotel Leaves Off"

(Week of October 3)

The principal difference between a hospital and a hotel, says _____ (name), superintendent of _____ Hospital, is that the hospital begins where the hotel leaves off. In other words, the superintendent explained, the hospital offers practically everything that a hotel does (and much of its service, such as meals, nourishments, general nursing, etc., is not extra, nor indicative of a "tip") and after that it offers specialized services needed by the physician to combat disease or other conditions which threaten the patient's life. Nobody would go to the finest hotel for treatment when ill, added the superintendent, yet many people think that there is no difference between hotels and hospitals.

Following out this line of thought the superintendent listed the following departments or services which the local hospital has, which is not to be found in a hotel: laboratory, X-ray, special diets, nursing, surgical (note: add any others such as oxygen therapy, physical therapy, etc.).

Many States Add Year to M. D.'s Study

(Week of October 10)

After a medical student is graduated from school he can not practice his profession legally in 17 states until

he has served an internship, or year of practical application and study in a hospital approved for this purpose by the American Medical Association. This is a far cry from the "good old days" when the young man "graduated" after a varying time of apprenticeship with a doctor, commented _____ (name), superintendent, _____ Hospital yesterday. This requirement of a year in a hospital after completion of a medical course has been adopted since 1919, thus indicating the progress that medicine continues to make. There now are 674 hospitals approved for internship, and these hospitals have places for 6,154 young medical graduates. (If your hospital is approved for internship, add sentence to this effect.)

It Pays to Re-study Your Methods

A visitor to a hospital recently was surprised to see that a product used in the laundry was a material that was refined and processed far beyond the point necessary for this particular use. The same product in a cruder form, but just as suitable for the purpose, could be had for from one-fourth to one-third the cost of the processed article. When attention was called to this wasteful practice, the visitor was told "Why, we have always used this material for this purpose." This is an instance of the value of checking or of re-studying methods, material, equipment, etc. It may be that in your hospital due to an emergency or for some other non-permanent condition, certain preparations or procedures were once authorized, that have been continued despite the fact that the conditions long ceased to be effective and that since that time cheaper materials would have done just as well, or certain protective measures need no longer have been taken. It pays to make a study of departments occasionally, veteran administrators assert, and the example cited above is proof of this.



New Jersey Completes Study of Chronic Disease

THE New Jersey Department of Institutions and Agencies, William J. Ellis, commissioner, recently completed a study of chronic patients in the state, some highlights of the survey, as seen by Commissioner Ellis being reprinted as follows:.

"This survey indicates there are under the care of social welfare and health agencies 150 chronically ill for each 100,000 of New Jersey's population, or approximately one for each 650 residents. It appears there are 6,000 to 7,500 chronic patients under the care of various agencies, and since similar studies indicated that but one-third of the chronically ill are known to welfare agencies, it is safe to estimate there are more than 20,000 chronically ill in the State.

"About 70 per cent of the chronically ill known to welfare agencies are under the care of institutional agencies, and 30 per cent under the care of other agencies. Five chronic diseases account for more than 50 per cent of the patients:

- 17.0 per cent Diseases of the Heart
- 12.1 per cent Arthritis and Rheumatism
- 11.2 per cent Cerebral Hemorrhage and Shock
- 6.9 per cent Cancer and other Malignant Tumors
- 6.2 per cent. Paralysis other than Cerebral Hemorrhage

"Almost 20 per cent of the chronic patients were less than forty years of age, 5.5 per cent were under sixteen and 12 per cent were between sixteen and thirty-nine. More than 50 per cent of the 2,032 cases studied were under the care of health and social agencies for more than a year; 37 per cent from one to five years, and about fourteen per cent for more than five years. Of 1,817 chronically ill, about 63 per cent were totally incapacitated and the remainder partially so.

"A comparison of the care needed and received by 2,187 patients showed that less than half of them were rendered suitable care, leaving 1,164 persons for whom modification of care would be necessary to be adequate for their needs.

"There are few institutions in New Jersey which recognize care of the chronically ill as their special function and adjust their programs and facilities to this work.

"So that the chronically ill in New Jersey may have the care they need, it will be necessary to enlarge existing

facilities and adapt others to their special needs. In the care of chronics, consideration should be given to the use of home care, nursing homes, homes for aged, general hospitals, welfare houses and almshouses, and hospitals for chronic diseases.

"Welfare Houses or Almshouses. Although a considerable proportion of the population of New Jersey almshouses is chronically ill the almshouses generally are not equipped to give the medical or nursing care required. The welfare house or almshouse is likely to be the ultimate refuge for most of the indigent or semi-indigent chronics, and the counties and municipalities will therefore in all likelihood be faced with the necessity of providing adequate medical and nursing facilities for the indigent aged.

"Hospitals for Chronic Diseases. A hospital for chronic diseases combines the services of a general hospital and a nursing home. It is designed to give the chronically ill specialized medical care such as is available to the mentally ill and tuberculous. It has a hospital section to provide medical care and a custodial section for domiciliary care.

"Home Care. A large portion of the chronically ill are cared for in their own homes, happy under familiar surroundings. It is the responsibility of the community to provide adequate nursing services, with a sufficient number of visiting nurses to render service to the patients and advice to the families. Public funds should be available for those families requiring assistance in caring for chronic members.

"Nursing Homes. These agencies are equipped to give nursing or cus-

todial care, intermediate between home and hospital care, to patients of moderate means. They are subject to State inspection and license and they assure proper treatment under standards requiring that a graduate nurse be in charge and that there be no less than one nurse to five patients.

"Homes for the Aged. Although these homes by their very names imply care for the chronically ill, but few have hospital or infirmary units and resident nurses. Although some have been more progressive in these respects, all homes for the aged must recognize their responsibility and broaden their admission policies regarding the chronically ill. Every home for the aged should have a graduate or experienced nurse, and make possible custodial care for chronic patients.

"General Hospitals. As organized at present, these agencies generally do not find it advantageous to give prolonged care to chronic patients. The reason is twofold; because it is outside the routine and out of proportion in cost to the need of the patient. To care for such patients, it may be feasible to: (a) establish special wards; (b) affiliate with convalescent or nursing homes to assure care for the chronic after passing acute illness; (c) extend dispensary and special clinic services, with sufficient social service-trained nurses to carry into the home prescribed methods of care.

"In 1931, 11 per cent of the 44,135 deaths in New Jersey were due to cancer. Competent authorities estimate there are three times as many existing cases as there are cancer deaths, which brings the total of cancer cases in the State to more than 14,000 in 1931.

"In view of this situation, cancer must be recognized as a public health problem of the greatest importance."

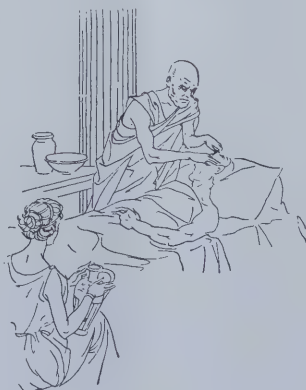
The survey was made by Emil Frankel, Ph.D., and Dr. Ellen Potter of the divisions of research and medicine.

NURSING FIGURES

According to a recent compilation by Mary A. Moran, secretary, Delaware board of nurse examiners, in 1928 there were six schools in the state, which admitted 112 probationers and accepted 65 students. In 1931 there were seven schools, these admitting 143 probationers and accepting 83 students.

NEWS OF INHERITANCE

The United Research Company, 125 West Madison Street, Chicago, is endeavoring to locate Rose Goodman, a registered nurse, who from 1900 to 1910 was employed at Michael Reese Hospital, Chicago. She is being sought to be advised of an inheritance in need of her care and attention.



15 Years Ago—THIS MONTH—10 Years Ago

From "Hospital Management," September 15, 1917

American College of Surgeons to study details of hospital standardization at meeting in Chicago in October.
Committee on Nursing, Council of National Defense, undertakes campaign to increase number of students in schools of nursing.

Recent changes: William Breiting to Lancaster General Hospital; Dr. R. L. Leak to State Hospital, Columbia, S. C.

Hospital superintendents relieved to learn interns were granted exemption from draft law.
War-time topics feature Cleveland program of A. H. A.

From "Hospital Management," September 15, 1922

A. H. A. getting ready for twenty-fourth convention on Million Dollar Pier, Atlantic City, first gathering outside of a hotel. Dr. George O'Hanlon president.

Hospital superintendents take elaborate precautions against coal shortage, due to general strikes.

Convention exhibitors plan organization meeting in connection with 1922 A. H. A. convention.

Fliny O. Clark, president, plans for second convention of Protestant Hospital Association.

\$4,000 Loss Changed to \$4,000 Surplus in 7 Months

By EDWARD GRONER

Superintendent, Baptist Hospital, Alexandria, La.

OUR hospital was on the verge of being forced to close its doors; in fact, the board in whose name the property is vested, was in favor of turning the hospital over to bondholders. The hospital, with a capacity of 65 beds, operated at a deficit of about \$1,000 per month for 1931. The auditor's report made January 15, 1932, showed a loss of \$3,977.65 since October 31, 1931, or an average loss per month of \$1,591.06 for the two and one-half month period. On May 31, 1932, just four and one-half months later, the auditor made another report which showed a surplus for the four and one-half month period of \$4,089.67, or an average surplus of \$908.81 per month.

On January 15, 1932, a newly appointed hospital board and superintendent took over the management of the hospital and immediately set to work to overcome the losses which the hospital had been experiencing. We discovered several ways in which expenses could be decreased, or income increased, some of the most important of which are briefly outlined herein:

1. Collections. During the year 1931 the cash collections averaged 80 per cent of the business booked. We have increased this to an average of over 92 per cent at the present time by requiring deposits weekly in advance, and in instances where this could not be done, we have insisted that satisfactory financial arrange-

ments be made, usually by securing indorsed notes.

2. A pharmacy was established in the hospital under the direction of a local pharmacist on a percentage of profits basis. Heretofore all drugs had been purchased at a local pharmacy. Not only has our cost of drugs been cut considerably, but the hospital's part of the income from the pharmacy has averaged over \$100 per month. In addition to dispensing drugs, the pharmacy also handles coffee, soft drinks, sandwiches, etc.

3. The hospital established an anesthesia department, employed a competent anesthetist, and required that all gas anaesthetics in the hospital be given by our anesthetist. This action met with the disapproval of several doctors; however, within thirty days the entire staff was cooperating with us. The net income from this source has averaged over \$150 per month.

4. After careful analysis of cost of operating a school, it was decided to employ a graduate staff and abolish our school. This action has not only improved our efficiency, but has cut down our operating expenses considerably.

5. Buying has been put on a conservative basis. Practically all items are now purchased on competitive bids and we are buying in larger quantities and on standing orders at a substantial saving.

6. One floor of the hospital was closed as reduced occupancy had made this space unnecessary. We are rent-

ing rooms on this floor to friends and relatives of patients.

7. Our fuel cost has been cut considerably by putting in a modern gas range. We are now arranging to purchase a small boiler to supply the sterilizers with steam instead of operating our large boilers for this purpose. A considerable saving should be realized.

In addition to these items we have established a central supply room, put into effect a schedule of flat rates payable strictly cash in advance, and made several adjustments in rates.

We are endeavoring to keep our hospital before the public in every possible way. All items of interest concerning the hospital are sent to the newspapers. We had the local luncheon clubs as our guests on National Hospital Day and welcomed many other visitors to inspect our hospital on that day.

There are probably many other small hospitals throughout the country on the verge of closing their doors which if they made a careful analysis of each item of expense and revenue, could find ways and means of turning a deficit into a surplus.

A BRIDGE BABY

Deaconess Hospital, Evansville, Ind., attracted considerable attention recently by offering free service to the maternity patient whose baby was born nearest to the time set for the official dedication of the Evansville-Henderson Ohio River bridge. The husband of the woman who was adjudged winner was a guest of the hospital at the civic banquet in connection with the dedication.

HEALTH INSTITUTE

A health conference will be held at Hampton Institute, Hampton, Va., October 14 and 15, under the auspices of the school of nursing of Hampton Institute, Nina D. Gage, director. It will be open to all the public health nurses in Virginia who care to attend, health teachers of the Y. W. C. A., members of the Parent-Teacher Association, and any others interested.

A. C. S. Hospital Program At St. Louis, Oct. 12-17

MONDAY MORNING

Jefferson Hotel

Allen B. Kanavel, M. D., Chicago, presiding, American College of Surgeons, presiding.

Address of welcome—Curtis H. Lohr, M. D., St. Louis, hospital commissioner.

Greetings from the president-elect—J. Bentley Squier, M. D., New York.

Report of the Fifteenth Annual Hospital Standardization Survey and Official Announcement of the 1932 List of Approved Hospitals—Franklin H. Martin, M. D., Chicago; director general, American College of Surgeons.

The Standardized Hospital as a Medical Education Center for the Community Profession—Allen B. Kanavel, M. D.

Discussion—Horace J. Whitacre, M. D., Tacoma, Wash.

Medical and Hospital Economics—Daniel Crosby, M. D., Oakland.

Discussion—Frederic A. Besley, M. D., Waukegan, Ill.

How the Hospital Management and Medical Staff Can Co-operate in Reducing Mortality Rate of Appendicitis—John O. Bower, M. D., Philadelphia.

Discussion—George David Stewart, M. D., New York.

Oxygen Therapy in Hospitals, Equipment and Management of Service—William Thalheimer, M. D., Chicago.

Discussion—George W. Crile, M. D., Cleveland.

MONDAY AFTERNOON

Pertinent Problems Affecting Hospitals and Their Solution—From a Nation-wide Survey—E. Muriel Anscombe, R. N., St. Louis; superintendent, Jewish Hospital.

Discussion—W. Hamilton Crawford, Hattiesburg; superintendent, South Mississippi Infirmary.

Economic Conditions as Affecting Canadian Hospitals and How These Are Being Met—Arthur J. Swanson, Toronto; superintendent, Toronto Western Hospital.

Discussion—Ross Millar, M. D., Ottawa; director of medical services, Department of Pensions and National Health.

Co-operation of Hospital Boards and Hospital Executives with Medical Staffs in the Diagnosis and Treatment of Cancer—Burton J. Lee, M. D., New York.

Discussion—Bowman C. Crowell, M. D., Chicago; associate director, American College of Surgeons.

Fusing the Triple Viewpoints on Nursing—Doctors', Nurses' and Hospital Executives—Mary M. Roberts, R. N., editor, *The American Journal of Nursing*.

Minimum Standards for Schools of Nursing—Rev. Alphonse M. Schwitalla, S. J., St. Louis.

MONDAY EVENING

Presidential meeting. A cordial invitation is extended to all the hospital delegates to attend.

TUESDAY MORNING

Tuttle Memorial Auditorium

L. H. Burlingham, M. D., St. Louis; superintendent, Barnes Hospital, presiding.

Symposium—Efficiency and Economics as Applied to:

(a) The Clinical Laboratory—J. J. Moore, M. D., Chicago.

(b) The X-ray Department—Edward H. Skinner, M. D., Kansas City, Mo.

(c) The Physical Therapy Department—John S. Coulter, M. D., Chicago.

(d) The Administration of Anesthesia—Joseph McNearney, M. D., St. Louis.

(e) The Administration of the Food Service—Eugenia Shrader, St. Louis; chief dietitian, Barnes Hospital.

(f) The Handling of Surgical Dressings and Supplies—Sister Philomena, St. Louis; supervisor of operating room, St. Mary's Hospital.

General discussion opened by E. E. King, St. Louis, superintendent, Missouri Baptist Hospital.

TUESDAY AFTERNOON

Round Table Conference—Administrative, Professional, Economic, and Social Problems as Affecting Hospitals—Conducted by R. C. Buerki, M. D., superintendent, Wisconsin General Hospital.

TUESDAY EVENING

Joint meeting for hospital trustees, hospital executives, and members of staffs.

Paul H. Fesler, Chicago, superintendent and trustee, Wesley Memorial Hospital, presiding.

Greetings from Hospital Trustees of St. Louis—Aaron Waldheim, St. Louis; president, board of directors, The Jewish Hospital.

Criteria to Be Observed in Selecting the Governing Body of a Hospital—C. W. Munger, M. D., Valhalla; director, Grasslands Hospital.

Responsibility of the Governing Body in Selecting the Superintendent—C. G. Parnall, M. D., Rochester, N. Y.; medical director, Rochester General Hospital.

Removing Hospitals from the Influence of Politics—John A. McNamara, Chicago; executive editor, *The Modern Hospital*.

Discussion—E. P. Hogan, M. D., Birmingham.

How Hospital Trustees Can Keep Abreast with the Advances in Hospital Administration—Matthew O. Foley, editorial director, *HOSPITAL MANAGEMENT*.

General discussion opened by Rev. R. D. S. Putney, St. Louis; superintendent, St. Luke's Hospital.

WEDNESDAY MORNING

Tuttle Memorial Auditorium

Bert W. Caldwell, M. D., Chicago; executive secretary, American Hospital Association, presiding.

Handling of Communicable Diseases in Connection with a General Hospital—Henry Rowland, Toronto; superintendent, Riverdale Isolation Hospital.

Discussion—Walter C. D. Kirchner, M. D., St. Louis; medical director, St. Louis City Hospital No. 1.

The Individual Doctor's Responsibility for Clinical Records—Walter F. Cole, M. D., Greensboro, N. C.

Discussion—Dewell Gann, Jr., M. D., Little Rock.

The Value and Scope of Medical Social Service Work in the Hospital—Grace Beals Ferguson, St. Louis.

Discussion—Robert E. Neff, Iowa City; administrator, Iowa University Hospitals.

How the Medical Social Worker Can

Assist in the Present Economic Situation—Ruth Lewis, St. Louis.

Discussion—Beryl B. Anscombe, R. N., Kansas City, Mo.; superintendent, Menorah Hospital.

The Role of the Social Worker in the Diagnosis and Treatment of Cancer—Eleanor Cockerill, St. Louis.

Discussion—Frank L. Rector, M. D., Evanston, Ill.; field representative, American Society for the Control of Cancer.

General discussion opened by B. A. Wilkes, M. D., Cape Girardeau.

WEDNESDAY AFTERNOON

Round Table Conference—Conducted by Robert Jolly, Houston; superintendent, Memorial Hospital.

WEDNESDAY EVENING

Community Health Meeting.

THURSDAY MORNING

Round table conferences and demonstrations at Jewish Hospital, conducted by Robert Jolly, Malcolm T. MacEachern, M. D., assisted by E. Muriel Anscombe.

Discussion and Demonstration of Preparedness for Emergencies in Hospitals—Jerome Simon, M. D., St. Louis, resident, St. Louis City Hospital No. 1; Clara Coleman, R. N., St. Louis, superintendent of nurses, St. Louis City Hospital No. 1.

Discussion of Operating Room Management with Demonstration of Detailed Procedure in Handling Major Operations—Max Myer, M. D., St. Louis, director of surgery, The Jewish Hospital; Marie Dowler, R. N., St. Louis, surgical supervisor, The Jewish Hospital.

Discussion of Food Service with Demonstration of Various Types of Tray Set-ups, General and Special or Therapeutic Diets—Llewellyn Sale, M. D., St. Louis, president, medical staff, and Bethel Curry, B. S., St. Louis, head dietitian, The Jewish Hospital.

Discussion and Demonstration of Handling Supplies—Purchasing, receiving, storing, distribution, exchange, economies, costs.—Florence King, St. Louis, The Jewish Hospital.

Staff Education with Demonstration of Nurses' Conferences—Purpose, time, place, procedure, problems discussed, benefits.—Edna E. Peterson, R. N., St. Louis; principal, school of nursing, Jewish Hospital.

THURSDAY AFTERNOON

Round Table Conference and Demonstrations at St. Mary's Hospital, conducted by Malcolm T. MacEachern, M. D., Robert Jolly, assisted by Mother M. Concordia, superintendent.

Discussion of Organization of the Hospital with Exhibition of Organization Charts—Rev. Alphonse M. Schwitalla.

Discussion of Admission of Patients with Demonstration of Procedure—

(a) The medical aspects of the problem.—Goronwy O. Broun, M. D., St. Louis, director of resident staff, University Hospital.

(b) The social service aspects.—Irene Morris, St. Louis, supervisor of medical social service, University Hospital.

Discussion of Nursing Administration and Nursing Service—Sister M. Henrietta, R. N., A. M., St. Louis, superintendent of nurses and associate director, School of Nursing, St. Mary's Hospital.

Discussion of Problems Associated with Clinical Records—E. Lee Shrader, M. D., St. Louis, director, St. Louis University student health service.

Discussion of Organization and Management of the Pediatric Division—Julius A. Rossen, M. D., St. Louis, pediatric division, St. Mary's Hospital.

WHO'S WHO IN HOSPITALS

MR. KING, who has been superintendent of the Missouri Baptist Hospital, St. Louis, for two and one-half years, after similar service with Baylor University Hospital at Dallas, and Baptist Hospital, Little Rock, recently had his responsibilities increased through his election as president of the Missouri Hospital Association. Mr. King is a graduate of Baylor University and is a native of Mississippi. He has been very active in Missouri and Mid-west Hospital Association circles since succeeding Dr. B. A. Wilkes at the Missouri Baptist Hospital, and for a number of years he has been a regular visitor at the American and Protestant Hospital Association conventions.

R. E. Heerman, for a number of years assistant superintendent of the California Hospital, Los Angeles, recently was named superintendent, succeeding George W. Olson, who in connection with pressing duties as vice consul in Los Angeles for the Swedish government, required more time away from the hospital. In connection with his consular work Mr. Olson, who was assigned to the Swedish Olympic team at Los Angeles, was given a leave of absence to carry out his responsibilities at the games. E. A. Morrison, president of the board of directors, and a business man and capitalist, who has been actively interested in the affairs of the hospital for more than eight years, has been appointed general manager of the hospital in charge of finances. Mr. Heerman, the new superintendent, has been active in association affairs, particularly in the hospital conferences at Southern California and Western Hospital Associations, and he has attended a number of American Hospital Association meetings. Mr. Olson is one of the best known figures in the field, having been interested in association work for many years. He organized the Minnesota Hospital Association and was its first president. He also was active in the Hospital Council of Southern California and served as president of the Western Hospital Association. He was vice president of the American Hospital Association and for a number of years has been active at its conventions.

Mrs. Z. V. Conyers has been appointed superintendent of the Sternberg Children's Hospital, Greensboro, N. C. She succeeds Grace Hansen.

Sister Oda, formerly superintendent

of Sacred Heart Hospital, Eau Claire, Wis., has been appointed superintendent of St. Mary's Hospital, Streator, Ill., and has been succeeded at Eau Claire by Sister Josepha, formerly of Green Bay, Wis.

R. A. Bates, some years ago superintendent of St. Luke's Methodist Hospital, Cedar Rapids, Ia., recently



E. E. KING

Superintendent, Missouri Baptist Hospital,
St. Louis

accepted a position as superintendent of Piqua Memorial Hospital, Piqua, Ohio.

Mrs. Beatrice Klein of Chicago recently was appointed superintendent of nurses of the Robinson Memorial Hospital, Ravenna, O.

Ella Costello, superintendent of nurses, Mary A. Wright, night supervisor, and Ruth Binder, training school instructress, recently resigned from City Hospital, Alliance, O. Mrs. Mary J. Taylor, a graduate of the hospital, and also a normal school graduate, has been appointed to succeed Miss Costello by H. W. Wagner, superintendent of the hospital.

Miss Grace G. Grey, formerly superintendent of nurses of the Jewish Hospital, St. Louis, Mo., who has just taken her master's degree in teaching in schools of nursing at Teachers' College, Columbia University, has succeeded Frances MacMillan as superintendent of nurses at Methodist Hospital, Indianapolis. Miss MacMillan resigned after eight years' service. She is widely known in the nursing field, having been a member of the Indiana state board of nurses'

examiners, serving as president and secretary. Miss Grey, who is a graduate of Sinai Hospital, Baltimore, formerly was educational director of the Los Angeles County School of Nursing and dean of nurses, University of Texas school of nursing, Galveston.

Miss H. Gladys Collins, formerly superintendent of Marietta Phelps Hospital, Macomb, Ill., has been appointed superintendent of Grant County Hospital, Marion, Ind.

Miss Clara E. Boeck recently was appointed superintendent of Lutheran Hospital, Beatrice, Neb., succeeding Delma Garrels.

Miss B. Flessner, superintendent of the Atlantic Hospital, Atlantic, Ia., recently resigned.

Ada Leonard, principal and instructor of the school of nursing of the Middletown Hospital, Middletown, O., recently was named superintendent, succeeding Mabel E. Pittman who resigned. Miss Leonard has been connected with the hospital and school for six years.

Dr. U. C. Ambrose recently was named president of the Indiana Christian Hospital, Indianapolis, under an administrative reorganization plan.

Dr. Edmund A. Christian on August 25 completed 50 years of service at Pontiac, Michigan, State Hospital, of which he is superintendent. He has been in charge of the institution since 1894.

Harold A. Chapin has resigned as superintendent of San Jose, Calif., Hospital, and has been succeeded by William P. Butler.

Anna K. Vogler, formerly of Flower Hospital, Toledo, O., now is superintendent of Riverside Community Hospital, Riverside, Calif.

Dr. L. H. Oliver and Dr. C. A. Dodson have opened the Friendship Hospital, Friendship, Wis.

Nellie G. Brown has been named acting superintendent of Ball Memorial Hospital, Muncie, Ind., of which the late Harold K. Thurston was in charge.

Mrs. Agnes D. Roberts is in charge of Brockport, N. Y., Hospital, which recently reopened. She formerly was in charge of Roberts Sanitarium, Rochester, N. Y.

Sister Lucille, formerly of St. Vincent's Hospital school of nursing, Jacksonville, Fla., now is superintendent of nurses at St. Mary's Hospital, Saginaw, Mich., succeeding Sister Miriam, who has been transferred to Brady Maternity Hospital, Albany, N. Y.

FOODS AND FOOD SERVICE

“Here’s What We Mean by Cost of Food and Meals”

Detailed Analysis of Food, Supplies, Equipment and Material Issued to Indiana University Hospital for One Week Shows How This Institution Figures Expense of Dietary Department

“OUR food cost is so and so.” How often does one hear a statement of this kind and then attempt to make a comparison of the food cost or meal cost of one’s own institution? A moment’s reflection will show that a brief statement that food cost is so much means absolutely nothing.

For instance:

How many patients were served during period?

How many employees?

Were actual meals counted, or was the total for meals arrived at by multiplying by three the average number of patients, plus the average number of personnel?

Were guest meals, meals to physicians or others included?

Even if all of these questions and several more were answered such as type of menu, percentage or special diets, etc., the person who attempts to compare his own food cost with a figure one has mentioned still faces an extremely difficult task.

That is why some superintendents refuse to figure meal costs for comparative purposes, contenting themselves with an estimate of raw food cost.

If these superintendents are asked about their meal costs they try to learn what the other hospital does in the way of including various items of overhead, etc., and then if a comparison is wanted, the first hospital gives its estimate by adding its own figures for the service costs, overhead, to its raw food cost.

How one hospital tackles the problem of figuring cost of food and meal cost was graphically outlined by Edward Rowlands, former assistant director, Indiana University Hospitals, Indianapolis, for the 1932 joint meeting of the Illinois, Indiana and Wis-

consin Hospital Associations. Mr. Rowlands made a careful compilation of issues of food, supplies, equipment and materials to the dietary department for the one week, divided this by the number of meals served and found that on this basis the cost per meal was slightly more than 18 cents, of which about 11½ cents represented the cost of the raw food.

It is interesting to note that Mr. Rowlands figured 5.8 cents as the cost of cooking. He arrived at a total cost of 18.17 cents per meal and a raw food cost of 11.44 cents.

A total of 17,830 meals in seven days, means an average of 2,547 daily, or about 850 persons served per meal. For this amount of service, the amounts of food and supplies listed elsewhere were required, according to Mr. Rowland’s compilation. The detailed list is of interest, not only in regard to individual items, but as a comparison, based on the relative proportion of meals in any other hospital.

Dr. E. T. Thompson, administrator, Indiana University Hospitals, thus comments on the way in which the cooking costs and number of meals were arrived at in the compilation:

“In regard to cooking costs and the number of meals served, I wish to inform you that the number of meals given is the actual number served. A count is made regularly each day of the number of patients receiving meals, and the number of people eating in the various dining rooms. We feel that our total number of meals served is very accurate; of course, there is always the possibility of slight miscount.

“Cooking cost, or more correctly speaking—the overhead cost of cooking—5.8c per meal, was obtained by setting up a cost accounting of the dietary department as follows:

“Costs to this department were distributed on several bases: namely—

- 1) Cubic content basis
- 2) Total budget ratio basis

How Indiana U. Hospital Figured Cost of 17,830 Meals

Total cost for raw food issued to Dietary Department.....	\$2,088.19
Less—Cafeteria for March 26 to April 1, inclusive.....	\$36.98
Cafeteria special service.....	4.20
Sale of food supplies.....	6.64
	47.82
Net cost of raw foods.....	\$2,040.37
Cooking Costs (17,830 x .058)	1,034.14
Table, Silver and Kitchen ware, Average.....	75.00
Office Supplies, Average	6.50
Cleaning Supplies, Average	38.50
Wearing Apparel, Average	7.50
Miscellaneous Supplies, Average	37.50
Total Cost.....	\$3,239.51
Total number of meals served	17,830
Per meal cost, total.....	\$0.1817
Per meal cost, Raw Foods.....	0.1144

Quantities of Foodstuffs Required for 17,830 Meals

FOODS	Amt.	Total cost	FOODS	Amt.	Total cost	FOODS	Amt.	Total cost
Bacon, lbs.....	244	\$25.20	Corn, No. 10, cans.....	32	14.08	Sugar, granulated, lbs.....	994 $\frac{1}{2}$	44.89
Bologna, lbs.....	10 $\frac{3}{4}$	.86	Cornflakes, boxes.....	39	3.12	Sugar, powdered, lbs.....	25	1.38
Beef, hindquarter, lbs.....	712	58.39	Cornstarch, lbs.....	30	3.00	Tea balls, individual.....	499	3.82
Beef, chipped, lbs.....	60	16.77	Dextrose, cans.....	2	.80	Tomatoes, No. 10, cans...	131	36.68
Butter, lbs.....	131	30.13	Flour, white, bags.....	12	20.88	Tomatoes, puree, cans...	36	6.12
Chickens, hens, lbs.....	127	29.09	Flour, Swansdown, bag...	1	2.47	Tomato juice, No. 10, cans	9	2.88
Chickens, broilers, lbs.....	237	56.88	Gelatine dessert, raspberry,			Tea balls, individual green.	156	.78
Eggs, doz.....	690	89.70	boxes.....	12	4.08	Vanilla, gal.....	1	2.65
Fish, lbs.....	130	20.90	Gelatine dessert, orange,			Vinegar, gals.....	7 $\frac{1}{4}$	1.09
Frankfurters, lbs.....	130	10.40	boxes.....	12	4.20	Crackers, white, cafe, lbs..	211 $\frac{1}{4}$	16.90
Hams, smoked, lbs.....	515 $\frac{1}{2}$	66.50	Ginger ale, bottles.....	24	1.92	Crackers, graham, lbs.....	151 $\frac{1}{2}$	1.40
Ham, minced, lbs.....	10	1.00	Grape juice, bottles.....	48	6.24	Wheat, puffed, boxes....	5	.60
Lard, lbs.....	100	6.00	Grapenuts, boxes.....	6	.90	Wheat, shredded, boxes...	23	2.30
Lamb, lbs.....	27	4.26	Jelly, donated, glasses....	3	.24	Wheat, food of, boxes....	40	4.00
Liver, beef, lbs.....	140 $\frac{1}{2}$	10.54	Jelly, mint, can.....	1	2.13	Yeast, Red Star, lbs.....	54	8.64
Oleo, uncolored, lbs.....	384	42.24	Jelly, raspberry, lbs.....	60	4.80	Apples, lbs.....	600	12.85
Oysters, qts.....	4	1.84	Jelly, currant, lbs.....	30	2.85	Asparagus, lbs.....	48	8.50
Pork, loin, lbs.....	63	5.73	Karo, No. 10, cans.....	2	1.12	Bananas, lbs.....	614	27.63
Pork, backs, lbs.....	258	23.48	Kraut, No. 10, cans.....	18	4.50	Beans, green, lbs.....	180	11.00
Beef, ribs, lbs.....	1,223	107.01	Lactose, can.....	1	.40	Bread, rye, loaves.....	10	.45
Spareribs, pork, lbs.....	12	.60	Marmalade, can.....	1	1.67	Bread, white, loaves.....	165	19.35
Sausage, link, lbs.....	24 $\frac{1}{2}$	1.78	Milk, condensed, No. 10,			Bread, whole wheat, loaves	20	2.40
Squab.....	1	.65	cans.....	140	12.00	Broccoli, bun.....	6	2.10
Beef tenderloin, lbs.....	30	8.64	Milk, malted, cans.....	23	2.07	Cabbage, lbs.....	130	11.25
Veal, hindquarter, lbs.....	207	31.05	Mustard, prepared, can...	1	.45	Carrots, fresh, lbs.....	240	11.00
Beef, knuckle butts, lbs...	260 $\frac{1}{2}$	26.05	Oats, rolled, bag.....	1	1.82	Cauliflower, lbs.....	160	15.50
Lamb racks, lbs.....	31 $\frac{1}{2}$	6.06	Oil, salad, gals.....	11	6.49	Celery, bun.....	21	9.45
Buttermilk, qts.....	110	5.50	Paprika, lbs.....	2	.76	Cheese, cottage, lbs.....	145	11.60
Cream, 20 per cent, qts...	309 $\frac{1}{2}$	68.09	Peaches, dried, lbs.....	50	5.00	Cheese, cream, lbs.....	85	12.75
Cream, 30 per cent, gals..	68	78.20	Peaches, diabetic No. 2,			Endive, bun.....	18	1.50
Cream, 40 per cent, qts...	19	7.22	cans.....	17	2.04	Egg whites, frozen, lbs...	31	3.72
Milk, skimmed, qts.....	14	.70	Peaches, No. 10, cans....	19	9.69	Grapefruit.....	510	20.40
Milk, certified, qts.....	143	25.74	Pears, No. 2, diabetic, cans	6	1.26	Kale, lbs.....	280	5.46
Milk, sweet, gals.....	1,155	231.00	Pears, No. 10, cans.....	46	27.14	Lettuce, head, lbs.....	350	15.00
Apricots, diabetic No. 2,			Peas, No. 2, cans.....	8	.96	Lettuce, leaf, lbs.....	90	4.60
cans.....	3	.63	Peas, No. 10, cans.....	50	21.50	Mushrooms, lbs.....	12	1.50
Apricots, No. 10, cans.....	12	7.44	Peas, pureed, cans.....	6	.84	Olives, green, gals.....	5	4.70
Apples, No. 10, cans.....	12	4.56	Pimentoes, No. 10, can...	1	1.03	Onions, Spanish, lbs.....	50	3.75
Asparagus, No. 2, cans...	8	1.92	Pineapple, No. 10, cans..	13	8.97	Oranges.....	4,550	113.78
Lactic acid, cans.....	1	.77	Pineapple, diabetic No. 2,			Parsley, bun.....	18	.60
Baking powder, lbs.....	5	.65	cans.....	6	1.17	Peas, green, lbs.....	180	23.25
Barley, lbs.....	5	1.00	Pineapple juice, No. 10,			Pickles, sour, gal.....	1	.49
Beans, green, No. 10, cans	56	19.04	cans.....	3	1.38	Pickles, sweet, gals.....	11	7.37
Beans, kidney, No. 10, cans	18	6.48	Pineapple mint, No. 10, can	1	1.88	Pineapple, fresh.....	144	21.00
Beans, lima, No. 2, cans..	2	.32	Plums, green gage, No. 10,			Potatoes, Idaho, lbs.....	400	8.00
Beans, navy dried, lbs...	100	3.50	cans.....	6	3.18	Potatoes, Irish, lbs.....	3,100	37.75
Beets, No. 10, cans.....	35	8.40	Preserves No. 10, cans...	6	7.08	Potatoes, sweet, lbs.....	180	3.40
Branflakes, boxes.....	27	2.16	Prunes, lbs.....	75	4.13	Potatoes, new, lbs.....	145	3.90
Beans, green pureed, cans.	4	.32	Ralston's, boxes.....	18	3.24	Rhubarb, lbs.....	197	14.00
Beverage, grape, cans....	18	11.52	Rice, bulk, lbs.....	100	4.00	Spinach, lbs.....	187	12.20
Beverage, orange, cans...	18	11.52	Rice, puffed, boxes.....	4	.60	Strawberries, qts.....	4	1.84
Carrots, pureed, cans....	6	.84	Salmon, cans.....	51	5.10	Tomatoes, lbs.....	30	4.08
Catsup, No. 10, cans.....	6	2.58	Salt, rock, bags.....	3	1.98	Watercress, bch.....	7	.30
Cherries, No. 10 R. A., cans	6	5.10	Salt, table, lbs.....	170	3.40	Rice Krispies, boxes.....	24	1.92
Cinnamon, ground, lbs....	3	.57	Soda, baking, lb.....	1	.05	Krumbles, boxes.....	10	11.00
Cocoa, bulk, lbs.....	45	2.03	Spaghetti, bulk, lbs.....	100	3.00			
Coffee, lbs.....	241	48.20	Sugar, brown, lbs.....	100	4.25			\$2,088.19

Here is a detailed compilation of foodstuffs, quantities and costs which entered into the determination of food costs, as explained in this article. On another page will be found similar information concerning various supplies and materials that entered into the cost per meal, etc.

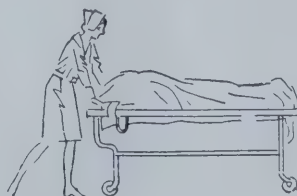
- 3) Total salary budget ratio basis
- 4) Direct charges basis
- 5) Patient day basis
- 6) Special basis

"On the cubic content basis, the following counts were distributed at the rate of 18.4 per cent, because this was the proportion of space allocated to dietary:

- a) Administrator's account
- b) Telephones
- c) Superintendents
- d) Work orders
- e) Carpenters

- f) Power plant
- g) Campus
- h) Heat, light, and power
- i) Water

"The following accounts were dis-



tributed on the total budget ratio basis:

- a) Assistant administrator
- b) Stores
- c) Accounting
- d) Purchasing
- e) Automobile

"The following account was distributed on the total salary budget ratio basis:

- a) Insurance

"The following accounts were distributed as direct charges:

- a) Dietary supplies

Supplies and Materials Needed for 17,830 Meals

OFFICE SUPPLIES

Registration of employes, cards	24	\$0.12
Requisition, repair, pads..	2	.12
Payroll voucher, pad.....	1	.54
Requisition, storeroom, pads	6	.51
Paper clips, box.....	1	.02
Labels, Dennison, No. 219, books	3	.60
Cards, ruled, 3x5.....	100	.08
Scratch pads, lbs.....	3 1/2	.28
Pencils, lead	12	.48
Thumb tacks, box.....	1	.10

\$2.85

CLEANING SUPPLIES

Bon Ami, bars.....	8	\$0.72
Buckets, mop	2	.68
Detergent, lbs.....	3	.21
Fly spray, gal.....	1	1.55
Lye, cans.....	4	.36
Mop heads, 24 oz.....	3	.90
Polish, silver, cans.....	2	.36
Dishwashing powder, lbs..	25	2.00
Soap chips, lbs.....	178	10.68
Soap, white floating, bars.	8	.24
Steel wool, lbs.....	4	.76

\$18.46

TABLE SILVER AND KITCHENWARE

Casserole	8	\$2.56
Cereal, Birdette.....	1	.30
Cereals, red and black....	7	1.75
Cereals, white.....	19	3.42
Custard cups.....	3	.24
Egg cups, Birdette.....	2	.64
Tea cups, Birdette.....	13	2.73
Tea cups, red and black..	26	5.72
Tea cups, white.....	7	1.05
Dessert dishes, glass.....	7	.56
Mugs, white, small.....	46	7.36
Mugs, white, coffee.....	24	3.84
Pitchers, water, glass....	3	.69
Plates, brd. and but., white	6	.48
Plates, dinner, red and blk.	11	3.08
Plates, dinner, white.....	21	2.52
Plates, salad, red and black	15	2.40
Sauce dishes, red and black	24	2.64
Sauce dishes, white.....	36	2.52
Saucers, red and black....	8	.88
Sherbets, Colonial.....	12	.48
Sugars, white, individual..	7	.56
Tumblers, Colonial.....	378	11.34
Tumblers, thin.....	10	.30
Dippers, ice cream, No. 10	2	2.60
Dipper, ice cream, No. 20.	1	1.65
Spoon, kitchen, serving...	1	1.19
Tea strainers, 2 1/2 in....	5	.30
Tea strainer, 9 in.....	1	.09

Butter spreaders, Washing-

ton	6	2.04
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\$66.83

MISCELLANEOUS

Souffle cups, small.....	100	\$0.18
Souffle cups, large.....	100	.22
Caps, milk bottle, paper..	1,000	.50
Lunch boxes.....	24	.24
Paper cans.....	200	2.10
Adhesive, roll.....	1	1.27
Paper bags, No. 5.....	2	.02
Paper bags, No. 10.....	48	.07
Tray covers, paper.....	7,000	11.97
Drinking cups, paper.....	100	.23
Drinking straws, boxes....	4	.84
Matches, boxes.....	43	.21
Napkins, paper, pkgs....	16	9.92
Paper, kraft, roll.....	1	2.16
Paper, shelf, sheets.....	15	.09
Paper, waxed, pkgs.....	7	1.26
Paper towels, pkgs.....	11	1.87
Graduates, 1,000 c.c. W. E.	3	2.88
Jar, W. E., 7 3/8 x 9 1/4.....	1	1.40
Bottles, nursing, 8 oz....	144	4.32

\$41.75

WEARING APPAREL

Coats, dietary	6	\$7.50
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Grand total.....\$2,225.58

- b) Dietary salaries
- c) Dietary miscellaneous
- d) Dietary depreciation
- e) Dietary gas

"The following accounts were distributed on the patient day basis:

- a) Linen room
- b) Sewing room
- c) Metabolism
- d) X-ray
- e) Drugs

"The following accounts were distributed on a special ratio basis:

- a) Laundry

"After calculating the total overhead charges and dividing by the number of meals served, the rate of 5.8c per meal was obtained. This figure, of course, will vary from year to year."

Special Diets Cost 7 to 10 Cents More

In letters received recently it was stated that the cost of special diets at Vancouver General Hospital was about 7 cents per meal more than for the regular menu, and that at Montefiore Hospital, New York, the cost of special diets averaged 10 cents more than regular diets.

"For the month of February, our raw food cost per capita per day was 33 1/2 cents, and for special diets it was 55 cents, which means about 7 cents a meal more for the therapeutic diets than regulars," wrote Ethel C. Pipes, director of dietetics at Van-

couver General. "If we are to encourage experimental work in diets and have the opportunity of testing the value of them (as in ketogenic diet, etc.) we need to be very careful in charges. In the case of staff patients, it is often cheaper for the hospital to bear the cost of special diet rather than medication, such as liver extract or other expensive drugs.

"Then there is the question of a fussy patient who is not a real special diet case, but demands a great deal of the dietitian's time, added expense for special foods and extra time from the cooks in preparation, and yet in this case it is only charged to the general satisfaction account."

"A few months ago we calculated the cost of our special diets and found that the average was approximately 10 cents per day more than our regular diets," wrote Lenna F. Cooper, supervising dietitian, Montefiore Hospital.

A. D. A. Program Gives Many Viewpoints

The program of the annual convention of the American Dietetic Association at Hotel Pennsylvania, New York, November 7-10, features many viewpoints on food problems and on dietotherapy.

Institutional dietitians, dietitians in public health and welfare work, school dietitians, dietitians in industrial and commercial fields, all have

representation on the program, while newest results in research and in various phases of dietotherapy will be described by physicians and others working in special fields.

Visitors will be busy with luncheons and breakfasts, in addition to the regular meetings, but ample time has been left for recreation and sight-seeing, and the local committee has made arrangements for some interesting trips and experiences.

Dr. Martha Koehne, University of Michigan, is president this year, and Dr. Kate Daum, University of Iowa, is president-elect.

The American Dietetic Association has made steady and rapid progress in membership, activity and influence, and it is expected that the 1932 meeting not only will be well attended, but that as in the past it will mark further development in the plans of the association for still better training and experience for members and for correspondingly better service by dietitians in the various fields in which they are engaged.

The tentative program for the meeting follows:

SUNDAY, NOVEMBER 6

10 a. m. Executive Committee meeting.
4:30 p. m. Tea in the lounge room, guests of the Hotel Pennsylvania

MONDAY, NOVEMBER 7

8:30 a. m. Registration.
11 a. m. General session, Dr. Martha Koehne, president, presiding. "Recent

(Continued on page 60)

**"Just
as good"
never is**

The imitator always apologizes. By imitation he is silently approving another man's work and automatically taking second place. The statement "just as good" is a confession of weakness. Beware of a product whose only endorsement is a claim to the prestige held by another.

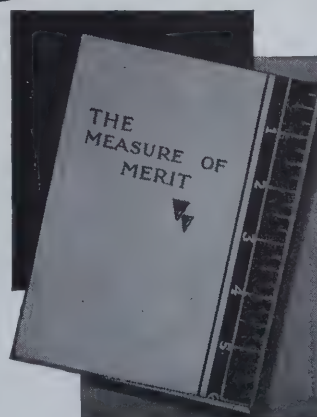


There are imitations of the Ideal Food Conveyor. There are food carts that look very much like an Ideal unit—in size, general appearance, color and finish. But the Ideal itself cannot be duplicated. Many of the features of the Ideal are exclusive—protected either by license or our own patent rights. Many points of construction cannot be matched by small manufacturers with facilities unequal to ours. No maker can build and profitably sell a food conveyor unit for as little money as we can. Don't be influenced by talk of lower price—for there is no lower price, merit considered, than the Ideal price. That's why "Most food conveyors are Ideals."

Manufactured by

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Toledo, Ohio

Ideal
Food Conveyor Systems



This little book, "The Measure of Merit," has become a sort of standard of hospital technique. Have you a copy?

"The More Suggestions Offered, The Better the Menu"

That Is the Belief of This Writer, Provided the
Suggestions Come from Those Wholeheartedly
Interested in the Work of the Dietary Department

By I. LESLIE HUNTER

Dietitian, Bridgeport Hospital, Bridgeport, Conn.

IN planning successful hospital menus, much time and thought must be spent in selection, preparation and serving of food—not forgetting the human elements which enter into its success. One should have a sound background in the essentials of a normal diet, but should not practice it at the expense of the individuals to be fed. In most instances, if one uses a little thought and a little self control, appetite is the best guide as to what one should eat and can eat. Therefore, in so far as possible, the likes and dislikes of the individuals should be considered and catered to.

I believe that dietitians as a whole try to introduce too much theory when feeding groups of people. It seems to be human nature to resent being told what one may or may not eat. The fate of one of the chain

"Too Theoretical?"

"I believe that dietitians as a whole try to introduce too much theory when feeding groups of people. It seems to be human nature to resent being told what one may or may not eat. To be sure, we must not ignore the essentials, but it seems unnecessary to overstress them."

restaurants under the vegetarian regime is an example of this. I sometimes feel conscience stricken when, upon checking the menus, I find meat and other protein foods (in no

small amount) appearing three times a day, but upon realizing that there are comparatively few complaints and in fact little sickness among the nurses and employes, I think that it is justifiable, somewhat more expensive, to be sure, but we are feeding the clientele rather than the garbage pails.

Some time ago I was introduced to a steward in the employ of one of the large railroad companies. Since I was curious to know if there were openings for dietitians in that field, the gentleman asked me what my profession was, and when told I was a dietitian he shook his head and said:

"Why choose such a stupid profession? Why, two of the most stupid girls I ever met were dietitians, graduates of one of our leading universities."

DATE	July 11	July 12	July 13	July 14	July 15	July 16	July 17
<i>Breakfast</i>							
Nurses	Bacon	French toast	Eggs	Grilled ham	Eggs	Sausage	Eggs
Doctors	Bacon and eggs	Bacon and eggs	Bacon and eggs	Bacon and eggs	Bacon and eggs	Bacon and eggs	Bacon and eggs
Private patients	Bacon and eggs	Bacon and eggs	Bacon and eggs	Bacon and eggs	Bacon and eggs	Bacon and eggs	Bacon and eggs
Wards	Eggs	Eggs	Eggs	Eggs	Eggs	Eggs	Eggs
Help	Eggs	Eggs	Eggs	Eggs	Eggs	Eggs	Eggs
<i>Dinner</i>							
Nurses	Corned beef	Roast lamb	Steak	Baked pork chops	Fish	Beef a la mode	Roast turkey
Doctors	Corned beef	Roast lamb	Steak	Baked pork chops	Fish	Beef a la mode	Roast turkey
Private patients	Roast beef	Roast lamb	Steak	Chicken fricassee	Fish	Beef a la mode	Roast chicken
Wards	Corned beef	Roast lamb	Stew	Baked ham	Fish	Beef a la mode	Chicken fricassee
Help	Corned beef	Roast lamb	Stew	Baked ham	Fish	Beef a la mode	Loin of pork
<i>Supper</i>							
Nurses	Lamb chops or*	Chicken salad	Baked banana	Jellied veal loaf	Boiled salmon	Broiled ham	Crab meat salad
Doctors	Steak	or* Ham and eggs	with bacon	or* Chicken pie	or* Cold cuts, fish	Baked beans	sandwich or*
		Broiled sweet- breads and bacon on toast rounds	or* Mixed grill	potato top	salad	or* Broilers	Turkey
Private patients	Chicken short cake	Italiane	Omelet	Lamb chops	Fish salad	Broilers	Turkey
Wards	Chicken stew	spaghetti	Scrambled eggs	Hash	Fish	Beef liver	Cold cuts
Help	Meat cakes	Creamed beef	Spare ribs	Hash	Fish	Baked beans	Cold cuts

*Doctors have a choice of nurses' supper or special supper provided.

"It has been found helpful in our institution to plan the meat menu separately, a week in advance; this gives a picture which simplifies the compilation of the meat order and insures the use of all cuts."

Exacting Requirements of Hospital Cookery

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The rigid cooking requirements of modern hospitals have inspired the making of Vulcan Gas Cooking Equipment. As a result, exactness of heat control, perfection in cooking and baking, reduced gas consumption, and a dependability demanded by hospital standards have been attained by Vulcan.

Over 100 gas cooking appliances are in the Vulcan line . . . from hot plates and ranges for diet kitchens to heavy duty ranges, broilers and bake ovens for the main kitchen. Vulcan equipment is giving satisfaction in thousands of hospitals, hotels, restaurants, schools and institutions.

Among many leading hospitals now using Vulcan Gas Cooking Equipment are the following:

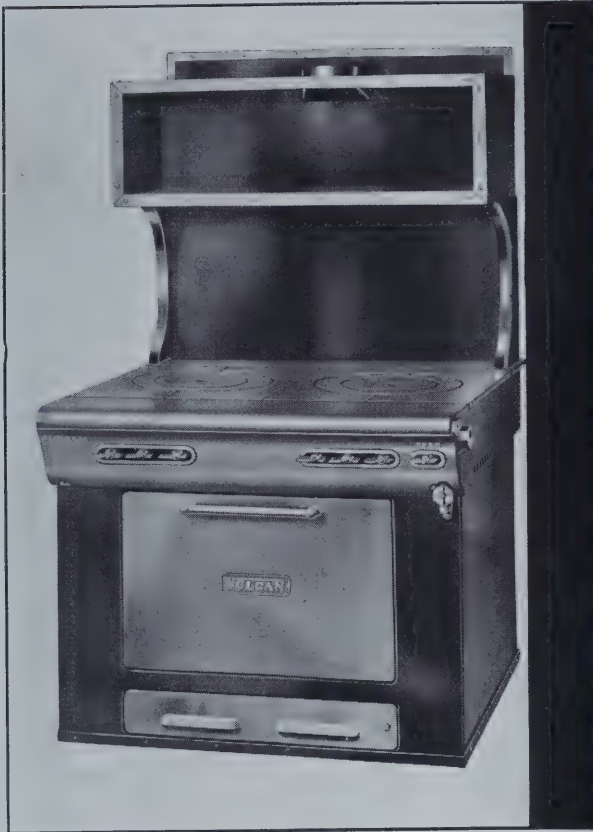
■ New York Cornell Medical Center ■ Walter A. Reed Hospital, Washington, D. C. ■ Lenox Hill Hospital, New York City ■ Jersey City, N. J. Medical Center ■ St. Luke's Hospital, New York City ■ St. Joseph's Hospital, Milwaukee, Wis. ■ Portland Medical Hospital, Portland, Ore. ■ Hamilton Co. Tuberculosis Sanitarium, Cincinnati, Ohio ■ Philadelphia General Hospital, Philadelphia, Pa. ■ Colorado State Hospital for Insane, Pueblo, Col. ■ Knoxville General Hospital, Knoxville, Tenn. ■ Essex County Hospital, Cedar Grove, N. J. ■ Massachusetts Memorial Hospital, Boston Mass.

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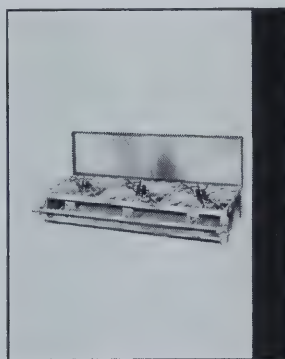
**VULCAN EQUIPMENT MAKES GAS THE MODERN
EFFICIENCY FUEL. CLEAN, FAST and ECONOMICAL**



VULCAN No. 4748 All-Hot-Top Gas Range



VULCAN No. 4712 Gas Range

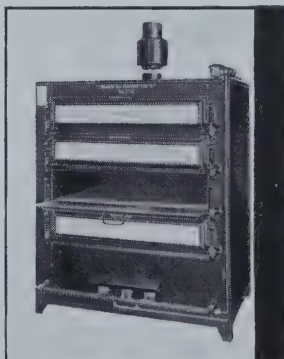


VULCAN No. 54 Hot Plate

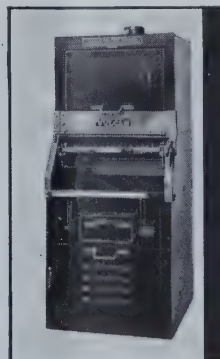
Vulcan No. 4748 large capacity, heavy duty "all-Hot-Top" range. Two triple ring burners provide two, large, red-hot center fires for speed boiling, with graduated temperatures to sides and back. Each ring is separately controlled. Fast, flexible, economical, easy to operate and keep clean.

Vulcan No. 4712 Junior range with Salamander broiler. Provides both open and closed top for varied cooking requirements of small hospitals, diet kitchens, etc.

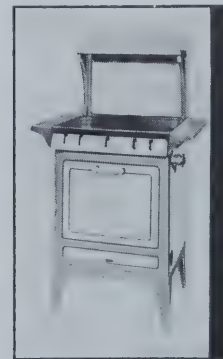
Vulcan Monel or Allegheny Metal Hot Plate No. 54. Used in large quantities for diet kitchens and serving rooms.



VULCAN No. 3762 Bake Oven



VULCAN No. 3758
Radiant Broiler



VULCAN Smoothtop
No. E-18-ET Range

Vulcan No. 3762 Insulated Heat Controlled Bake Oven. Provides large capacity, 4920 square inches, four decks, in small space. Two sizes.

Vulcan No. 3758 Radiant Surface Broiler. Ideal where requirements are heavy. Broils faster, does more work with less gas than any other type of broiler.

Smoothtop No. E-18-ET. Largely used for diet kitchens. Exceedingly compact. Provides closed top, high shelf, 18-inch oven and broiler, oven heat control.

ANNOUNCING...



... a New China that is Centuries Old

YEARS ago Spain knew it. So did Italy. Even Ancient Egypt worked their wonders in this magic clay. It first appeared on our continent in the far Southwest. The early Spanish padres fathered its use—in building their missions, their quaint homes, and in fashioning their charmingly simple tableware.

Now it re-appears—with all its original and glorious coloring. Adding warmth, informality, quaintness to the tableware and its surroundings. Transforming even the simplest meal into a pleasing, appetizing harmony of color.



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for Hospital Use

A tray that is pleasing to the patient's eye—isn't that your first concern? As you know, the optic nerves can do the rest. Given wholesome food, the big problem is to serve it in an appealing manner.

Some of our most valued customers are hospitals who have proved repeatedly the effect of the right china upon the appetite. We ask you to imagine yourself for a moment in a sick bed—viewing, as a patient, the china which illustrates these pages. Can you imagine any more pleasing or inviting dish, any surer way of making any diet appeal instantly to even the most reluctant appetite?

Adobe ware will have this effect

upon your patients—will improve digestion, increase their strength, keep them gaining, happy.

Don't let the thought of reduced budgets close your mind to this new development—the first contribution to the ceramic art in many years. You will find the new Adobe patterns in supply houses in all the larger cities. Color suggestions for your own special pattern will be furnished on request from our Syracuse office. What kind of service have you been considering? We should like to know.

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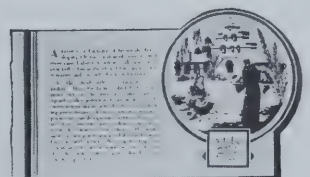
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One of the seven trays pictured and described in the booklet "The Perfect Tray" by Helen Evangeline Gilson, chief dietitian, Pennsylvania Hospital, Philadelphia. A copy will be sent on request.

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Need Help With Collections?

Here's a convenient, low-cost method that will help you with collections and other matters relating to cooperation of patients, visitors and the public.

“Hospitals must adopt a plan of public education. They must utilize every possible means of disseminating information about themselves,” says the 1932 A. H. A. report on public relations.

Instead of a mere statement of amount due, or a collection letter, why not enclose with your bills, a friendly, newsy pamphlet that is sure to be read by every former patient? Some thing that will give them reasons why the hospital needs money and why they should make as large a payment as possible now, if they can not pay in full?

As an aid to collections a hospital bulletin will pay for itself alone, but that's just one of the many things that a bulletin will do for you.

You'll be surprised at the cost, even when compared with 1932 prices.

A post card request will bring information fitted to your own problems.



HOSPITAL MANAGEMENT

537 So. Dearborn Street

Chicago, Illinois

	Breakfast	Dinner	Supper
Monday, July 18	Cereal Eggs Toast Coffee	Soup Baked ham Potatoes Creamed egg plant Pudding SOFT: Vegetable puree	Turkey stew Potato and lettuce salad Fruit, cake SOFT: Strained soup, baked potato, vegetable puree, stewed fruit HELP: Turkey stew
Tuesday, July 19	Cereal Eggs Rolls Coffee	Soup Boiled beef Potatoes Carrots Pudding SOFT: Vegetable puree	Macaroni and cheese Vegetable salad Fruit, cake SOFT: Strained soup, baked potato, vegetable puree, stewed fruit HELP: Cold meat
Wednesday, July 20	Cereal Eggs Toast Coffee	Soup Roast veal Potatoes Kohlrabi Pudding SOFT: Vegetable puree	Lamb stew Cold slaw salad Fruit, cake SOFT: Strained soup, baked potato, vegetable puree, stewed fruit HELP: Sausage
Thursday, July 21	Cereal Eggs Rolls Coffee	Soup Roast beef Potatoes Green beans Ice cream SOFT: Vegetable puree	Escalloped corn and peppers Egg salad Fruit, cake SOFT: Strained soup, baked potato, vegetable puree, stewed fruit HELP: Beef liver
Friday, July 22	Cereal Eggs Toast Coffee	Soup Fish Potatoes Beet greens Pudding SOFT: Vegetable puree	Fish, baked potato Lettuce salad Fruit, cake SOFT: Strained soup, baked potato, vegetable puree, stewed fruit HELP: Fish
Saturday, July 23	Cereal Eggs Rolls Coffee	Soup Stew Potatoes Cold slaw Pudding SOFT: Vegetable puree	Baked lima beans Tomato salad Fruit, cake SOFT: Strained soup, baked potato, vegetable puree, stewed fruit HELP: Baked beans, frank- furters
Sunday, July 24	Cereal Eggs Rolls Coffee	Chicken fricassee Potatoes Peas Ice cream SOFT: Vegetable puree HELP: Loin of pork, apple sauce	Cold cuts Potato salad Fruit, cake SOFT: Strained soup, baked potato, vegetable puree, stewed fruit

Here is a week's menu for ward patients and help, illustrating the ideas of the author. Compare with menus on page 58 and page 60.

I fear I registered indignation, but later gathered that their failure was due to trying to introduce too much theory of dietetics which would not have been tolerated by dining car clientele. To be sure, we must not ignore these essentials, but it seems unnecessary to overstress them.

The paper under discussion states that the protein dish is the keynote of the meal and we plan around it. This is most important. It has been found helpful in our institution to plan the meat menu separately a week in advance; this gives a picture which simplifies the compilation of

the meat order and insures the use of all cuts. These main dishes are then transferred to the regular weekly menu sheets where their accompaniments are added. Although the menus are planned a week in advance, it is with an understanding that they are tentative; sometimes they are subject to change daily. This is due at times to market conditions; at other times to the attempt to use up materials on hand due in part to a fluctuating census, and to make use of left-overs.

It is almost impossible to plan so as not to have left-overs. But what is to be done with these? They are certainly not to find their way into the garbage pail. Instead they are

put into a refrigerator used for left-overs and the first duty of the administrative assistant dietitian is to assign the food materials as part of the daily menu, thereby cutting down on the amounts to be prepared for that day's meal.

Regular daily inspection of all garbage containers makes it possible to know if a dish is being served that is not well received by the group. Prune whip left from the nurses' dining room is eagerly received by those on the women's wards, but disdained by those on the men's wards. This was discovered by garbage inspection and close contact with the head nurses.

At a daily conference of the supervisors of the food department the previous day's meals are considered in regard to the manner in which they have been received by the various groups. We have found, for example, that veal is not enjoyed as a roast, but is eaten with relish as steak or cutlet. The current menus are then discussed as to the method of preparation, the size serving, and the arrangement on the plate.

It has been found a helpful practice when using an expensive main course, such as steak, on the dinner menu, to employ the use of an inexpensive main course, such as fritters and a rasher of bacon, on the supper menu; or if meat pie is served for dinner, lamb chops may be used for supper. When the staff nurses and private patients receive steak, the employes and wards are served beef stew or meat pie made from the trimmings of the loins, insuring good stew. For supper the wards may be served cold cuts and the employes pork chops. In each instance we try to balance the cost of an expensive food with that of an inexpensive one.

It seems that the old method of having a weekly set of menus, with no variation, to be followed to the letter, has passed. Some time ago at our institution it was felt that too much time was devoted to the planning and typing of menus. It was therefore suggested that we use a four or five-week set of menus. This led to a survey of menus for three years previous, with the result that we did not encounter an exact duplicate, which showed that the above principles had been applied in the planning. Repetition in menus was discouraged and we have continued to avoid it as much as possible.

It has been found in larger hospitals, where there is more than one dietitian, that it is wise to have different members of the department work on the planning. This leads to the possibility of the introduction of

This paper has been rewritten from a discussion of a paper on menu planning by Marion Floyd, chief dietitian, Massachusetts General Hospital, given before New England Hospital Association.

	Breakfast	Dinner	Supper
Monday, July 18	Fruit Cereal Bacon and egg Rolls or toast Coffee	Bean soup Steak Boiled or mashed potatoes Fresh lima beans Orange nut salad Vanilla cornstarch Berry sauce	Chicken a la Crane on toast Parisienne potatoes Tomato salad Fruit Chocolate walnut cup cakes
Tuesday, July 19	Fruit Cereal Bacon and eggs Rolls or toast Coffee	Julienne soup Pot roast Mashed potatoes Green beans Jellied peach salad Whipped cream dressing Tapioca cream, cherry	Asparagus on toast O'Brien potatoes Sweet bread salad Fruit Peanut butter cookies
Wednesday, July 20	Fruit Cereal Bacon and egg Rolls or toast Coffee	Tomato rice soup Chicken fricassee Parsley or mashed potatoes Carrots Fresh pineapple and marshmallow salad Grape ice	Lamb chops Potato, cheese balls Cucumber salad Fruit Brownies
Thursday, July 21	Fruit Cereal Bacon and egg Rolls or toast Coffee	Lentil soup Roast beef Mashed potatoes Squash Cantaloupe and cress salad Chocolate Charlotte	Mushroom caps on toast Baked sweet potato Chicken salad Fruit Cocoanut frosted cup cakes
Friday, July 22	Fruit Cereal Bacon and egg Rolls or toast Coffee	Cream of celery soup Fish, sauce Mashed potatoes Fresh spinach Waldorf salad Apricot whip with cream	Escalloped sea food Potato on the half shell Lettuce hearts, club dressing Fruit Almond wafers
Saturday, July 23	Fruit Cereal Bacon and egg Rolls or toast Coffee	Puree of green pea soup Roast lamb, mint jelly Parsley or mashed potatoes Fresh peas Grapefruit and fresh pear salad Apple brown Betty, whipped cream	Broilers, toast points Escalloped potatoes Stuffed pepper salad Fruit Yum yums
Sunday, July 24	Fruit Cereal Bacon and egg Rolls or toast Coffee	Roast chicken, jelly Dressing, gravy Mashed potatoes Cauliflower Celery and olive salad Fresh peach sundae	Cold turkey, cranberry sauce Combination salad Baked potatoes Fruit Buttermilk cake

Compare this menu for private patients with menu for same period for nurses and staff (page 60) and for ward patients and help (page 57).

new dishes and new combinations. Careful checking of the menus and innovations should be required, however, and when possible by the head, who is directly responsible for the success or failure of the food service.

In considering the menu in relation to the employees it seems wise to include them in the planning by soliciting their ideas and suggestions. The meat menu compilation is quite an event at our hospital. The chef puts on his cleanest togs and comes into the dietitian's office, where he presents the meat refrigerator inventory. Meat quotations are then gone over and we proceed with the planning. The result is that many at-

tractive meat combinations are presented and there is never reason for criticizing the menu on the part of the employees, as their off-time has been considered, also the limitation of the equipment; in short, their interests have been represented by the chef, and one seldom hears, "There is too much work."

Suggestions from the employees are listened to and encouraged. In fact, all are made to feel, no matter how humble their position, that they are a vitally important part of the department, as, of course, they are. Sometimes when it is necessary to change, say, the breakfast fruit, and we are using oranges in place of

grapes, it often occurs that orange is again represented in the salad. This may be overlooked in the office, but almost without exception we are reminded of it by the salad girl; she is always thanked for being observant and her help is often solicited to suggest another material to be used.

In hospitals where nutritious and simply and carefully prepared foods are required, it has been found that hotel chefs are not entirely satisfactory, they tend to be extravagant, wasteful and reckless in their use of seasoning. A good cook, however, one with a knowledge of meat cutting and one who will follow carefully tested recipes, proves more satisfactory. To be sure, he needs close supervision, but he does not resent it as do hotel chefs. I cannot overstress close supervision, as nearly all the time one is seeing something to be improved upon and checked.

Should the dietitian do the buying? That is a question to be decided upon by the administration of the individual hospital, but she should frequent the market, as daily she will discover something new that can be used to advantage in her menus. For example, she may requisition "fresh peas," which have suddenly soared to \$9 a basket, and the market offers lima beans at \$4 a basket, or broccoli at \$1.50 a bushel. The result is, the purchasing agent either buys an expensive vegetable which brings up the cost unnecessarily or he fails to place the order, which causes great inconvenience.

SPECIAL DIET COSTS

According to the annual report of Miss R. M. Park, dietitian, the Montreal General Hospital in 1931 had 1,113 patients on special diet regimen, this figure representing a daily average of 60 patients per meal, or 15 per cent of all patients in the hospital. The dietary department reported an average cost per meal of 33 cents for the diet kitchen, including the metabolic kitchen, and an average cost of 18 cents per meal for the main kitchen.

Miss Park reported the following volume of service:

Meals served:

Main kitchen, 809,505.

Diet kitchen, 95,413.

Metabolic kitchen, 58,842.

This was a total of 963,760 meals, or a daily average of 2,640 meals.

"One of the major activities of the department," said Miss Park's report, "is that of teaching student nurses, dietitian interns, patients attending the weekly outpatient diabetic clinic and all in-patients requiring special dietary instruction. Sixty hours' practical dietetics was conducted for the probationers and 24 lectures in diet therapy given to the senior nurses, followed by six weeks of diet preparation in the diet kitchen. A six months' course in hospital dietetic administration and dietetics has been given to 14 dietitian interns."



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	Breakfast	Dinner	Supper
Monday, July 18	Oranges Prepared cereal or Cream of Wheat Sautéed apples Water rolls Coffee	Bean soup Baked ham, dill pickles Boiled new potatoes Fried egg plant, to- mato sauce Vanilla cornstarch Fresh berry sauce	Minced turkey on toast with bacon Hot sour beets Cucumber salad Fresh peaches Chocolate walnut frosted cake
Tuesday, July 19	Plums Prepared cereal or oatmeal Eggs Wonder rolls Coffee	Julienne soup Meat pie, cold slaw Parsley, new potatoes Green beans Blueberry cottage pudding	Cold cuts Potato salad Corn on the cob Watermelon Peanut butter cookies
Wednesday, July 20	Bananas Prepared cereal or Farina Bacon Pointed rolls Coffee	Tomato rice soup Veal steak Currant jelly Mushroom gravy Mashed potatoes Kohlrabi Grape ice	Hamburger with tomato Corn fritter Hearts of lettuce Spring dressing Fresh green apple sauce Brownies
Thursday, July 21	Grapefruit Prepared cereal or Wheatena Creamed beef All o' the Wheat rolls Coffee	Vegetable soup Roast beef, gravy Browned potatoes Summer squash Ginger bread, whipped cream	Stuffed peppers, sauce Baked noodles with raisins Fresh peas Cold slaw salad Blackberries Cocoanut frosted cake
Friday, July 22	Oranges Prepared cereal or cornmeal Potato cakes Parker House rolls Coffee	Cream of celery soup Fish, sauce Mashed potatoes Fresh spinach Cherry pie	Shrimp salad Potato chips Fresh lima beans Sautéed tomatoes Baked plums Spice cake
Saturday, July 23	Pears Prepared cereal or Cream of Wheat Eggs French rolls Coffee	Puree of green pea soup Breaded cutlets, sauce Parsley potatoes Creamed cauliflower Apple brown Betty, whipped cream	Chicken delight sandwich Corn in cream Fresh pineapple Boston cream pie
Sunday, July 24	Melon Prepared cereal or oatmeal Deerfoot sausage Cinnamon buns Coffee	Tomato juice cocktail Roast chicken Cranberry sauce Dressing, gravy Mashed potatoes Fresh peas Celery and olives Fresh peach sundae	Combination meat Egg and vegetable plate Baked potatoes Raspberries Buttermilk cake Iced tea, lemon

Here is a week's menu for nurses and staff, made up according to the ideas and principles explained in the article on page 56.

A. D. A. Program Gives Many Viewpoints

(Continued from page 54)

Advances in Nutrition," Dr. Henry Sherman, Columbia University.

1 p. m. Welcoming luncheon.

2:30 p. m. Annual business meeting, Dr. Koehne presiding.

7 p. m. Annual banquet, Dr. Koehne presiding. Address, Dr. Lafayette B. Mendel; address, Dr. Mary Swartz Rose.

TUESDAY, NOVEMBER 8

10 a. m. Joint session of Social Service and Education Sections, Laura Comstock and Dr. Mary de Garmo Bryan presiding.

12:30 p. m. Flavor luncheon. Program by New York City Home Economics Association, Edith Barber, president, presiding. Address, Mr. Sweeney, Hotel Statler; address, May Van Arsdale, Teachers College.

2 p. m. General session, Mary Lindsley presiding. Address, "Special Problems in the Administration of the Institution Food Unit," Cora C. Colburn, Yale University.

Ten minute talks on food topics: Helen Stacey, special assistant, American Telephone & Telegraph Company; Harriet Stone, supervisor of nutrition, Newark Public Schools; Adeline Wood, chief dietitian, Mt. Sinai Hospital, New York, "Buying Meat; Study of Cuts"; Emma Holloway, supervisor of institutional courses, Pratt Institute, Brooklyn, N. Y., "The School Cafeteria as a Unit in Teaching Institutional Courses"; S. A. Larrison, refrigeration engineer, New York City, "Refrigeration."

4:30 p. m. Surprise entertainment at American Women's Association, guests of Greater New York Dietetic Association. Trip through the largest women's club building.

7 p. m. Foreign dinner, theater, and Broadway on election night.

WEDNESDAY, NOVEMBER 9

10 a. m. General session, Dr. Kate Daum presiding.

"Feeding the Family in an Emergency," Lucy Gillette, A. I. C. P., New York.

"Taking Institutionalism out of the Institution," Dr. Alfred F. Hess, New York.

"Problems of Feeding and Rationing

Federal Prisoners," Dr. Paul H. Howe, United States Department of Agriculture. 12:30 p. m. Exhibitors' luncheon, Mary Barber, presiding.

2 p. m. Joint session of diet therapy and administration sections, Mrs. Dorothy Stewart Waller and Faith McAuley presiding.

4 p. m. Trip to Columbia University nutrition laboratories; tea at Pratt Institute.

7 p. m. Dinner for heads of departments giving approved training courses. Open also to representatives of college home economics department, Dr. Mary de Garmo Bryan presiding.

Evening. Trips to Waldorf-Astoria Hotel, an ocean liner, Chinatown, or the National Broadcasting Company.

THURSDAY, NOVEMBER 10

10 a. m. General session, S. Margaret Gillam presiding.

"Food and the Mind," Dr. Earl Bond, Philadelphian.

"Food Sensitiveness and Intolerance," Dr. Maximilian A. Ramirez, New York.

"The Role of Diet in Tropical Medicine," Dr. T. T. Mackie, New York.

12:30 p. m. Affiliation luncheon, Dr. Koehne presiding. Open only to delegates.

2 p. m. General session, Mary Pascoe Huddleson presiding.

"Anemia Studies," Dr. Frieda S. Robscheit-Robbins, University of Rochester Medical School, Rochester, N. Y.

"Anemias: Clinical Study," Dr. Randolph West, Presbyterian Hospital, New York.

"Present Status of the Ketogenic Diet and Its Use," Dr. Clifford Barborka, Chicago.

4 p. m. Trip to Good Housekeeping Institute. Air trips.

7 p. m. Foreign dinners. Theater. Midnight market trip.

FRIDAY, NOVEMBER 11

Trips to hospitals: Columbia Medical Center, Cornell Medical Center, Mt. Sinai, Fifth Avenue, or Bloomingdale.

Air trips.

Trips to Empire State Building, Walker-Gordon Dairy Farm, or museums.

DIETITIAN INTERNS

Dr. Martha Koehne, president of the A. D. A., recently visited Methodist Hospital, City Hospital and the Indiana University Hospitals, Indianapolis, in behalf of internships for student dietitians. Dr. Koehne holds an associate professorship with the dental department of the University of Michigan.

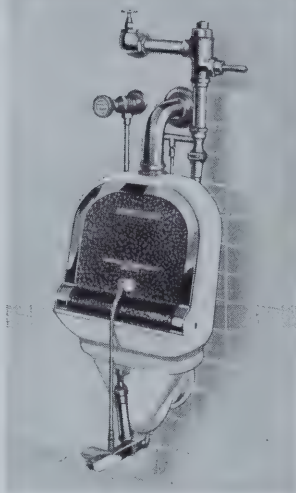
Hazel Larson, a graduate of Montana University; Bernice Bratz, a graduate of the University of Wisconsin, and Erma Cox, a graduate of the University of Kentucky, are recently accepted dietitian interns at Methodist Hospital, Indianapolis, of which Margaret D. Marlowe is administrative dietitian.

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"The dietary department served 281,972 meals at a cost of 17½ cents per meal," says the latest report of Children's Hospital, Denver. "In spite of the fact that there was an increase of 17,437 in the number of meals served, a saving of \$1,591.58 was effected in the cost of food. In no case was the quality reduced, and fresh fruits and vegetables were used throughout the year. The dietary department with an expenditure of \$49,811.94, of which \$31,596.72 was for food alone, represents a sizable grocery business."

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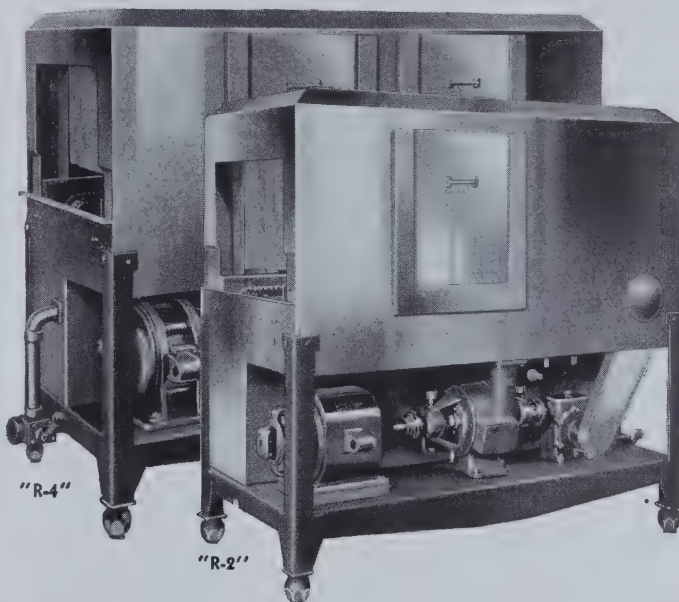
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The Record Department

How a Doctor Would Improve Charts and Records

By Edmund J. O'Shaughnessy, M. D.,
Stamford Hospital, Stamford, Conn.

THE value of the chart to the physician depends a great deal on the power of observation of the nurse, neatness in writing or printing, legibility, the shortness and conciseness of the remarks regarding patient's reaction to treatment, or to the disease. It is not sufficient to state that the pulse is 80 and not mention that it was irregular, weak, full or bounding.

The temperature chart should be ruled and the dots carefully placed, it also should show whether taken by mouth, rectal or axilla.

I think that rather than using adhesive tape to join sheets together, it would be better so to space the ruling that one sheet would suffice for two weeks, then run consecutively 1, 2, 3.

The amount of urine voided should be measured and charted each time. Anything unusual should appear under "remarks." The amount of fluid taken should also appear. The doctor's visits should be charted; if any unusual examination or treatment, it should appear, as often when the patient is sick "no expense is to be spared," but when the patient gets well it is very hard to understand the bill or why the number of visits. At the end of the day it should be ruled off and the amount of intake and output noted.

In other words, the chart should be a picture of the patient, his symptoms, reactions to treatment or disease, mental as well as physical, since last visit. It is very important that the chart should be up to date always; it is of no use if it is only up to yesterday afternoon.

It would also facilitate reading if each department had its own color. For instance, if you wished to find what the neurologist's findings were on January 7, you would turn to the pink sheet and find January 7 and read his diagnosis over his own signature. He does not have to write his opinion himself, it is written by the intern as he dictates it, and signed before he leaves the patient.

As to progress notes, they should be written at the bed side to be of any value, for if they are written a few hours or days later a certain amount of detail has been forgotten.

As to closed cases, the chart should show in addition to the general information, the disposition of the case, transferred, improved, cured, died, the diagnosis, complications, and possibly some of the symptoms which are not entirely understood, or where there are two or three theories as to their production.

A proper holder of records is necessary in order to keep the sheets in good condition while the patient is in the hospital. One of the best I have seen has a double hinge. In order to read the record one hinge opens, but to take out or replace a sheet, the second hinge has to open. This is a spring hinge and holds the sheets like a loose-leaf ledger. This holder is made of metal and no clips are needed. This helps to prevent wrinkles.

A nurse's reputation is made or marred by the records she keeps; if her charts are neat and can be read at a glance, she is usually an efficient nurse. But if her charts are sloppy, carelessly written, and the doctor throws them aside because they are too difficult to read, the nurse usually belongs to the class

that considers nursing to mean giving medicine at 2:15, and that giving medicine is nursing. What I mean is that giving medicine is the smallest part of nursing.

As for cross indexing, a suggestion might be, to have printed at the bottom half of the outside sheet, the names of a number of diseases, and the names of some unusual symptoms. As, for instance, a patient is received with a broken thigh. While in bed he develops pneumonia, then he develops pleurisy with effusion which is aspirated, and in a few days empyema ensues. This causes a toxic general condition, which is the cause of myocarditis, the actual cause of death. These causes or events could be checked as "1-2-3," or "a-b-c," or with different colored pencils. Then when you pick up the chart you would see the sequence of events. Now in cross indexing, this patient would appear under the headings of pneumonia, pleurisy, empyema, and myocarditis.

Under the heading of "laboratories," space might be given for electrocardiogram, clinical laboratory, autopsy findings, both gross and microscopical.

Specialties for those interested in the heart: rheumatic fever is one of the causes of heart disease. The etiology or cause is not very well known, therefore, their chart should contain something like this:

Focal infection,		
Tonsils	When removed	Condition of teeth
	Before first attack	Condition of sinuses
	After first attack	Cheyne-Stokes
Tonsils	Fully removed	Stokes Adams
	Piece left in	Recurrent laryngeal constant
	Lingual	Valve lesions—not constant

This method or suggestion of classification might also be of use in the case of the patient discharged from the hospital and referred to the clinic. A duplicate of the summary or disposition sheet would accompany the patient, so that the clinic doctor could get at a glance about what the hospital had done for the patient, and he could pick up the case from that point and not have to lose time asking questions or trying to look over the whole record of the case. This applies equally to the clinic patient sent into the hospital. It would save duplication, as often a patient is X-rayed twice because the second examiner did not know until too late that it had already been done.

Team work between the interns and nursing staff to save time:

First: Interns should have the patient's history and physical examination on the chart before the visiting doctor sees the patient.

Second: The charts should be up to date, not half a day behind time. Temperature, pulse and respiration should be put on the chart at bedside, not left to the night nurse. This also applies to the history and progress notes.

Third: The charts should be put in rack in rotation in which the beds run, in order to save time in finding a chart. This certainly can be done for staff cases. For the associate staff, they should be sorted as the beds run and under the doctor's name.

Fourth: When the staff visiting doctor arrives, a nurse should carry all staff charts and hand to the intern at each bed. The intern should make notations as to visiting doctor's findings and the doctor should initial them.

Fifth: The visiting doctor draws attention of the intern to symptoms or signs, their reasons, and to the nurse what concerns her.

Sixth: The intern should be encouraged to observe symptoms and attitudes; he should endeavor to make a diagnosis without the aid of the laboratories, using the laboratories for corroboration, bearing in mind that the postmortem may prove or disprove his diagnosis. By laboratories I mean the X-ray and electrocardiogram.

—From a paper before Connecticut Record Librarians' Association.

ATTRACTIVE ANNUAL

The 1932 edition of the Nucleus of the Robert Packer Hospital School for Nurses, Sayre, Pa., recently was received. It is up to the high standard that previous issues of this interesting publication have set. One purpose in publishing such a volume is to convince the public of the fact that schools of nursing are educational institutions. Howard E. Bishop is superintendent of the Robert Packer Hospital and Nina A. Smith, R. N., is directress of nurses.



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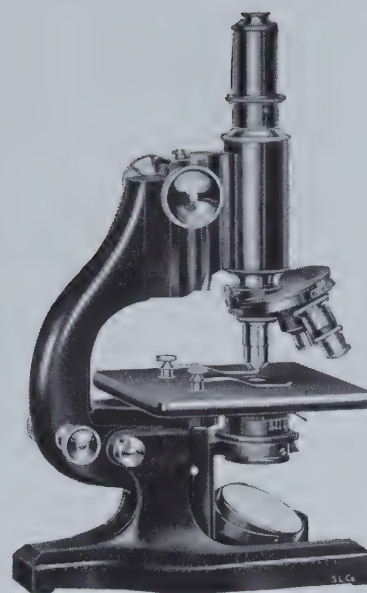
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What a Hospital Expects of a Record Librarian

By Charles H. Pelton, M. D.

Assistant Superintendent, Boston City Hospital, Boston, Mass.

WE must be fair. I believe that we should expect something of ourselves and have something to offer really worthwhile to the record librarian. So it is only reasonable that the hospital be prepared to furnish a decent workshop—a pleasant niche in the general scheme of the institution—a fair technical set-up in the way of materials with which to work. It is most important that we place at her command and ready for her use the proper tools—well lighted rooms, typewriter, a certain amount of privacy in the workshop, a definitely thought out program against which she can build her efforts, and last but by no means least, the full-hearted cooperation and support of both the medical staff and the administrative powers of the hospital.

In the last analysis the record librarian represents the administration as the guardian of the written record of the second most important function of any hospital—namely, education of doctors and nurses in so far as the immediate care and treatment of the patient is concerned.

Some years ago in a certain hospital it was found necessary to make a complete study of the clinical record department. As a matter of fact, it was really no department at all, but just a room with some filing cabinets, cards with titles, a handbook of nomenclature, some fairly standard forms for history taking (and most of the latter bore mighty scarce evidence of any written clinical endeavors even though the patients did “sleep well,” as stated by the nurses on duty at the time). That condition just could not go on if any progress was made and the hospital was to earn its rightful place in the sun. After expending much effort and time both the governing board and the visiting staff agreed to furnish the moral and financial support to bring about the desired changes. Those of you who have been through like experiences will, I am sure, fully appreciate what a task lay ahead. Now then, the first thing was *cherche la femme*—and fortunately we did.

This hospital expected a woman with a high school education or its equivalent, interested in the problem presented, experienced in typing and shorthand, with personality, a pleasant demeanor, and an evident desire to learn her job from the ground up. With these things as a basis on which to work and after some months of close application it was found possible to whip the department into shape so that it was felt that the clinical records from then on could be considered of some real value to all concerned. Of course, had it been at all practicable to do so it would have been much more desirable to have obtained the services of a record clerk with whom it was not necessary to check such detail, one whose training had been acquired in a large and well conducted record department.

You will note that I have not made any mention of the age of a record librarian. It does not seem to me that the age of the individual is an entirely essential consideration—*plasticity* of mind is the important item. *Personality*—that indefinable something to which we all instinctively respond in others—is a most desirable characteristic. If this something be repellent, rest assured that so much the more difficult will it be to encourage the physicians on the staff to come to the record room and there lend their

efforts to lighten the burdens of the occupant of that position. Closely allied to personality is *tact*. Many are the occasions on which the record librarian finds it necessary to exert every ounce of this that she may be fortunate enough to have.

To return to the experience above noted, may I add that an opportunity was given to the young woman mentioned to visit several larger hospitals in a neighboring city and there study methods and details. This was found very valuable—gave her a broader viewpoint and stimulated her to pattern her work after that of the leaders.

Devotion to her work—without this there will be more than one temptation to quit, for in this work one can easily become discouraged and feel that all efforts are futile. Hand in hand with devotion to the work we rightly expect loyalty. As in any other position, loyalty to one's employers and to oneself is highly essential.

The hospital looks to the librarian to display a deeply *ethical* attitude. For this reason, if for no other, she has at her disposal and command the most intimate details regarding the patients, whose physical and family affairs are laid out before her in black and white, and the blacker they may be the greater the need for strictest use of ethics.

Assuming that the administration has set up a definite policy as to making and use of records, the rules so laid down should be strictly adhered to. It is expedient that great care be given to the exposition of details needed for purposes of research—legal reports, replies to queries made in letters from various agencies, and control of all information sought from the record department.

If the librarian has one or more assistants working under her direction she must be able to efficiently supervise their efforts and inculcate in them the same close application to principles which she is expected to evince in her own immediate work. There must be prompt follow up on all deficient records. Assuming that there be a record committee of the staff, this committee should be able to leave to the librarian the working out of the more intimate details in order that their time can be given to the questions of policy and that they may convey to the staff—both visiting and house—the necessity of ever striving to meet the ideals of a perfect record system.

It is quite likely that if her fundamental education has given her an opportunity to study Latin she will find her pathway much smoother, especially in the use of her medical dictionary. Much useful information may be acquired in the judicious and careful use of a dictionary and Latin is a marvelous help in learning the derivation of the terms commonly found in medical histories. I believe it valuable for the librarian to be instructed in the matter of costs for running the department.

When at all possible, the record librarian should be expected and encouraged to attend meetings of the association. These meetings will be found a source of information giving an exchange of practical ideas and opportunities to obtain a broader attitude toward the daily tasks. The association has already accomplished much of value for its members and the hospitals represented.

LABORATORY MANUAL FOR NURSES

C. V. Mosby Company, St. Louis, Mo., recently published “Clinical Laboratory Manual for Nurses and Technicians” by Sister Alma, chief laboratory technician, St. Thomas Hospital, Akron, O. Price \$1.75. This book frankly states that it deals with laboratory technique in elementary style and is intended to give student nurses an appreciation of the necessity of observing technique. The book treats mainly of tests in which the nurse's cooperation is needed and tells how the specimens should be collected and handled.

Read at the conference of the New England Hospital Association, 1932.



While Jeanne Biscot is known for a wide variety of charitable enterprises, one of the remarkable things about her career was her intelligent application of sound principles of what we now call "occupational therapy."

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X-ray, Laboratory Service

X-ray Equipment, Methods of Tacoma General

By Alan L. Hart, M. D.,

Director, Radiological Laboratory, Tacoma General Hospital, Tacoma, Wash.

THE Tacoma General Hospital recognizes the necessity of maintaining an X-ray department, properly equipped and adequately manned, in addition to the laboratory of clinical pathology. The services of both these departments, it is felt, add to the value as well as to the cost of hospital maintenance. The increased expense should, of course, be borne, at least in part, by the patient. Many hospital administrators look with an anxious eye toward the receipts of the radiological laboratory as a source of income for the hospital as a whole. We do not believe, however, that it is necessary for the X-ray department to be a source of revenue.

It is highly desirable that the roentgen laboratory should be run on a full time basis with a full time medical director. In most small and medium-sized hospitals it is not possible to pay a sufficient salary to insure an adequately trained man full time in this department. It is, therefore, necessary to allow the roentgenologist to do private work in order to insure him a satisfactory income. It is a matter of detail to be decided according to the merits of each individual case whether this is done by working on a percentage basis or by allowing the physician himself to equip the laboratory privately and arrange for the hospital work to be done by his own staff in addition to his private referred work. Collections may be made in the department or in the hospital office, according to local conditions.

Certain facilities must be on hand in order to do good radiological work. Apparatus for both fluoroscopic and radiographic work of considerable variety is required. In the Tacoma General Hospital these include two Bucky tables, a plate changer for chest work, accessories for the examination of sinuses and mastoids, and apparatus for urological and gastro-intestinal studies. The latter comprises, in addition to the ordinary tilting table, a compression device for the examination of the pylorus and duodenum and a serialograph for stomach exposures in the recumbent posture. There is also a urological table with a Bucky diaphragm for kidney studies.

The main radiographic room is 13 feet 8 inches by 17 feet. A Bucky table and vertical plate changer for chest films occupy one wall. On the opposite side of the room is an alcove just large enough for the control stand and meters. Accessories are kept in shelves near this alcove. The remainder of the floor space is clear except for a movable tube stand. This gives sufficient room for handling patients on stretchers and moving the hospital carts about, without disturbing the patients on them.

The second radiographic room is 9 feet 10 inches by 17 feet. It contains a shockproof X-ray machine and a second Bucky table. This apparatus can also be used, if needed, for horizontal and vertical fluoroscopy. There is plenty of space in the room for moving patients from

stretchers to the table for any radiological work that can be done with the patient lying down.

The third radiographic room is 8 feet 8 inches by 12 feet 9 inches, and is used for fluoroscopy and gastro-intestinal work only. It contains a tilting table which gives positions from erect to Trendelenberg at will. A combination switch permits instantaneous change from fluoroscopic to radiographic current for making films during the screening of the stomach. Off this room is a small toilet for the use of patients.

The urological work is done in another room containing a transformer and a cystoscopic table with a Bucky diaphragm.

The dark room is 6½ feet by 10 feet. It is located between the two main radiographic rooms. The entrance is through one end, and in the other end is an outside window; this permits thorough airing of the room at intervals. All the fixtures in this room were built in the hospital. Near the entrance is the loading bench, with film bin and pigeon holes for loaded cassettes underneath and film hangers above it. An L-shaped tank fills the end of the room and part of the other side-wall; it is made of cedar, lined with ⅛ inch lead. It is filled with water, and in it is room for the smaller tanks containing developer and fixing bath, as well as space for washing the films. A dryer with a suction fan occupies the remainder of the side-wall. The walls of the dark room are green, and the ceiling white. The general illumination is indirect, from an Eastman safety lamp suspended from the ceiling, and is supplemented by smaller safety lights above the loading bench and developer tanks.

An ill-advised economy sometimes practiced is the making of two few films. The day has passed when three or four stomach films and a film of the colon at 24 hours and another at barium enema comprise a satisfactory gastrointestinal study. Economy can better be served by careful planning of the floor space and selection of apparatus, so that more work can be done by the personnel with less exertion and in a shorter time.

All the films of each examination are put together into a heavy manila envelope and placed in a moderate-sized, steel filing cabinet in the office of the department. On the envelope are written the patient's name, the date of the examination, the X-ray serial number, and the part of the body examined, and to it is pasted a carbon copy of the roentgenologists' report. As the filing cabinet is filled, the films in their envelopes are transferred to an underground storage chamber, separate from the hospital. The shelves in this room should have vertical partitions, so that the envelopes may be filed vertically, since it is then easy to find and get out any desired set of films.

A cross index of all roentgen examinations is kept. One file consists of an alphabetical index according to the patients' names. On these cards appear the name, the date, the region of the body examined and the X-ray number. Another file consists of an alphabetical index according to the region of the body examined, and the third of an index according to the diagnosis made. These two latter files make it easy to select a number of illustrative films for teaching or demonstration purposes.

Care in purchasing is necessary in an X-ray department. A constant supply of fresh films can best be as-

(Continued on page 70)

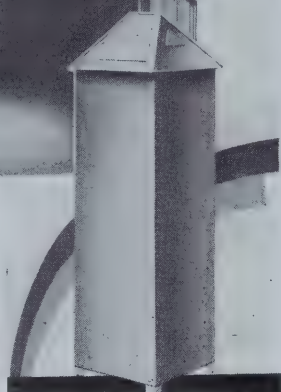


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The Nursing Department

Extra-Curricular Activity of Phila. General

By Loretta M. Johnson, R. N.

Superintendent of Nurses, Philadelphia General Hospital,
Philadelphia, Pa.

THE extra curriculum is a part of the actual curriculum in the Philadelphia General Hospital School of Nursing, and with all-round preparation the student is prepared for not only citizenship, but a fuller and more complete life, not merely choosing nursing as a vocation.

We have learned from experience that youth no longer accepts with blind obedience that which authority sees fit to order, and that they are critical and weigh every idea, person and thing. Curricular activities are an invaluable aid for the wise guidance of youth.

We employ a full time social director who lives in the Nurses' Home, and has been prepared in physical training, and is an unusually talented young person. Through her efforts, she has made the girls believe that they are a happy addition to the student body, and that individual personalities will not be entirely submerged in the large group. Interest is stimulated in things other than nursing, and while her duties are primarily concerned with the students, the social director devotes part of her time to the graduate nurses in the Hospital.

The Preliminary students find upon their arrival at the Hospital that a complete readjustment is necessary for happiness, and to make new friends, adapt themselves to a new environment, is not an easy adjustment; a person serving in the social capacity is very helpful to these young people.

Many opportunities are given for formal advice about personal behavior, cleanliness, styles of dress, habits, etc. Training in parliamentary procedure, arrangements for parties, dances, and class activities, and to have some person as a counsellor is very helpful.

During the early period of training, the social director attempts to supervise the healthful aspect of our students, instructing them in personal hygiene, checking on weights, and supervising the serving of extra nourishment to underweights at 10:30 each morning, at which time chocolate and crackers are available for the nurses on duty. If they are incapacitated by illness, daily visits are made and a word of cheer exchanged.

Educational tours are conducted periodically during the preliminary course, and groups of the students are taken through the Mulford Chemical Laboratories, Wistar Institute of the University of Pennsylvania, Abbott Dairies, and some of our very interesting historical Philadelphia buildings and large stores.

A Student Government Association composed of the entire student body functions as a complete unit with the officers and members of student council, elected once each year. Through this organization and the social director, a program of recreational activities is arranged throughout the year.

Once each month, preferably on Sunday afternoon, an informal afternoon tea is served in the living room of the nurses' home with the Superintendent of Nurses and

various members of the Faculty pouring, and the student nurses serve in the capacity of hostesses.

The school orchestra, composed of the student nurses, furnishes selections of a classical nature which form the classical entertainment for those in attendance. Attractive sandwiches and fancy cakes are prepared and served to the guests.

Many hours of practice and conscientious interest have made it possible for our Director to organize a school Glee Club, which is quite a talented group, and has contributed its services to the Dramatic group when plays were given.

In order to function successfully, the various clubs find it necessary to have funds available for progressive work, and many interesting sales have been conducted throughout the year. A bazaar was held in the nurses' quarters this winter, and attractive booths draped and lighted held many lovely gifts which netted a goodly sum. A tea room, organized by the nurses and arranged with attractive gingham draperies and table coverings created an atmosphere of an old Dutch shop, dimly lighted by candles, and the waitresses appeared in native costume. Tea, sandwiches and cake were served, and we believe the desire to permanently conduct such a tea room is deeply imbedded in their minds.

Joining the local Basketball League for Nurses interested a different group. These enthusiastic young women, just out of High School, were eager to take up the favorite school sport, and thoroughly enjoyed every game. Table conversation changed from Hospital news to our "Basketball team," and we feel that this form of recreation is valuable to the students.

In hot summer months, nothing is nicer than a cool plunge in a refreshing swimming pool, and the nurses spend many happy hours learning to swim. We are fortunate to have our own pool with scheduled hours for swimming under the supervision of the director.

Picnics and boat trips during the summer are arranged periodically, and the Hospital dietitians co-operate in packing delicious lunches.

Informal dances are held every Saturday evening in the nurses' home, and the nurses may invite their friends to join them. During the school year, the Student Government Association and various classes hold formal dances in the Auditorium of the Hospital, and many hours of planning and preparation make these successful social functions.

Frequently groups gather in the nurses' living rooms to receive instructions in card playing, and one evening a week our social director spends her time teaching the playing of bridge.

A Fiction Library and Club is necessary for any group of young people, and we are fortunate in having a full-time Librarian who makes our educational and circulating library a very important one. Fees for overdue fiction books and contributions from interested friends have made it possible for us to add many valuable books to our collection, and our student library club meets once during the month to discuss books, review and hear reports of the latest publications.

In our Educational Building, notices are posted of plays, pictures, entertainments, church meetings and activities, hikes and various other recreational programs,

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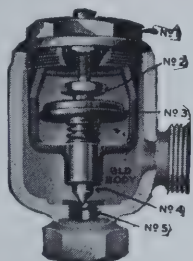
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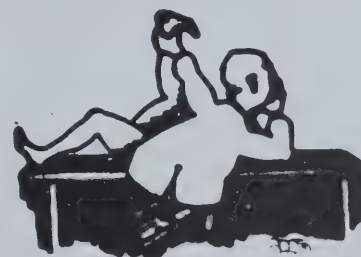
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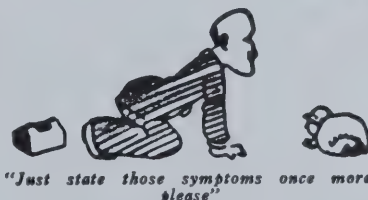
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whereby the nurses may plan for their off duty time. Periodically through the winter months, theatre parties to the popular plays are extended to our nurses, and this brings the group together in another respect.

We encourage the students to affiliate with the local churches, and in our own school have a very active Y. W. C. A., officers elected by the members of the organization, and religious gatherings held once a month on Sunday morning.

An inspirational fund has been created and maintained by the out-going senior classes to be used for speakers who come to us about four times a year. These talks leave with us standards and ideals of life and living which prove invaluable in adjustments for the future.

X-ray Laboratory, Tacoma General

(Continued from page 66)

sured by purchasing on a weekly or fortnightly basis from a dealer who keeps a revolving stock on hand.

In a hospital laboratory, many patients will be helpless and must be handled on stretchers and carts. This requires more floor space than in an office where only ambulant cases are examined. At least one room must be large enough for a cart to be turned around easily, and the doors must be wide enough to admit carts and beds. Furthermore, moderately large rooms permit the personnel to keep their distance from the X-ray tube in operation, than which there is no better protective measure.

X-ray departments *must not* be located in cellars where sunlight cannot enter and ventilation is impossible. There must be a sufficient number of technicians.

The Tacoma General Hospital has a separate installation for X-ray therapy. The same machine is used for superficial and deep therapy. Treatments are carried out, under the supervision of the director, by the same technicians who work in the diagnostic laboratory.

Although this hospital is not endowed for research, the director carries on a modest amount of investigation which is published from time to time in the radiological journals. He also has a weekly class (two hours) with the interns. Medical students get very little instruction in radiology in medical school. They must depend on teaching received during their internship for whatever they learn of the roentgen rays. We do not attempt to make radiologists out of our interns, but we try to teach them to recognize certain common lesions and injuries and to build up in them a fair appreciation of the value and proper use of radiology in medicine.

QUIT MAIL ORDER URINALYSIS

One of the large Chicago mail order houses in a recently issued catalog offered a urinalysis report for \$1.50. The American Medical Association made a survey of the service offered by the company as a result of which and also because of numerous letters from physicians, the service has been discontinued.

THE HOSPITAL CALENDAR

- Ontario Hospital Association, Toronto, October 26-28.
- American Dietetic Association, New York, November 7-10.
- Clinic Managers Conference, Mankato, Minn., October 13-14.
- Colorado Hospital Association, Colorado Springs, November 8-9.
- Mississippi Hospital Association and Mississippi State Medical Association, Jackson, April 10, 1933.
- Iowa Hospital Association, Marshalltown, April 19-20, 1933.
- South Dakota Hospital Association, Sioux Falls, 1933.
- Western Hospital Association, Long Beach, Cal., 1933.

THE HOSPITAL LAUNDRY

A WEEK'S LAUNDRY

Memorial Hospital, Johnstown, Pa., during the week of June 5-11, laundered 22,376 pieces. These were classified as follows, according to the hospital bulletin:

Blankets	503	Mattress covers.....	76
Laundry bags.....	85	Aprons	1,202
Scarfs	1,014	Bibs	790
Gowns	1,345	Cuffs	565
Large sheets.....	1,803	Curtains	57
Small sheets.....	802	Caps	242
Large spreads.....	1,017	Hangers	13
Small spreads.....	405	Underwear	240
Face towels.....	2,107	Napkins	1,520
Bath towels.....	1,451	Bath robes.....	10
Ice bags.....	113	Rag rugs.....	30
Pillow slips.....	1,639	Bags	94
Scultetus	95	Draw sheets.....	339
Binders	73	Handkerchiefs	35
Dressing towels.....	591	Table cloths.....	6
Wash rags.....	1,037	Coats	74
Bed pan covers.....	356	Trousers	77
Stockings	349	Socks	78
Masks	37	Blue uniforms.....	130
Screen covers.....	94	White uniforms.....	106
Diapers	1,276	Collars	220
Shirts	169	Belts	42
Pads	69		
Total			22,376

This hospital has 291 beds, including 31 bassinets, and it treated 5,069 patients in 1931.

ELECTRIC IRON IMPROVED

A new electric iron that provides more convenience and is less fatiguing has been announced. With the new conveniences, coupled with an increase in wattage, the ironing time can be lessened by one-third, it is said. This new iron has a slanting handle with a sponge rubber grip. This handle has been set at an angle to eliminate hand and wrist strain. The soft rubber sponge grip puts an end to callouses and blisters. The iron heats much faster than ordinary irons and it will maintain automatically any temperature selected, say the manufacturers.

SIMPLIFY LAUNDRY MACHINERY

Manufacturers of laundry machinery have been working on a simplification program during the past year through four committees covering extractors, tumblers, ironers and washers, says a recent note from the U. S. Department of Commerce, and as a result of their efforts a simplified practice recommendation for each of these types of laundry machinery has been proposed by the manufacturers.

SHOWS LAUNDRY SAVINGS

"The laundry plant completed in the early part of 1930 has operated since then with complete satisfaction," says the latest report of Homeopathic Hospital, East Orange, N. J. "For the present year the laundry cost shows a reduction of approximately \$3,500 in comparison with 1930, and a conservative calculation shows that the 267,316 pounds of laundry handled during the year would have cost us at least \$7,000 more if the work had been done outside. Moreover, this calculation includes \$2,682 for interest and depreciation, which was not an actual cash expense during the current year, so that from the cash standpoint there was an additional gain. Nor is the financial aspect the only advantage in the maintenance of our own laundry, as there are other important advantages such as convenience and a saving in linen."

"CAN'T CUT RATES"

Trustees of the Chicago Hospital Association at a recent special meeting decided that it would be impossible for hospitals to reduce rates and maintain the necessary standard of service. It also was agreed that the object of such a reduction, that is, the increasing of patronage, undoubtedly would not be gained thereby. It was suggested that patients of limited means be considered individually and given every possible aid.

RUBBER SUNDRIES CATALOG

The Miller Rubber Products Company, Inc., Akron, O., has just published its new catalog on rubber sundries, including a large number of new or re-designed articles for sale by druggists and used by physicians, surgeons, dentists, in hospitals and the home. Copies can be had on request.

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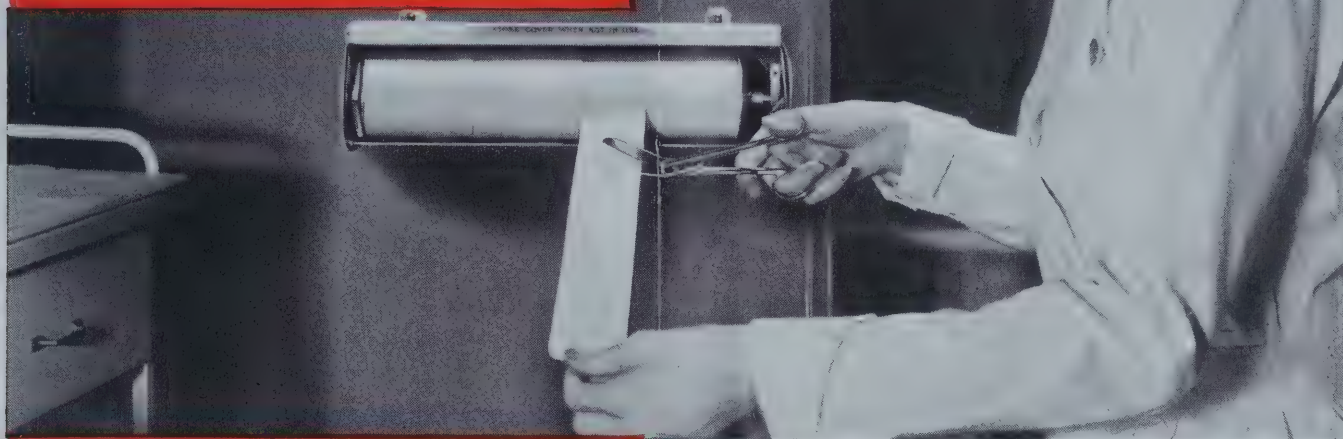
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1873 Stock exchange closed for nearly two weeks, 36 stock exchange houses failed within few days, \$750,000,000 railroad bonds in default, strikes and riots followed wage cuts, mills and factories closed, banks had recourse to clearing house certificates.

1893 Craze for formation of great trusts followed by failures on every hand, 467 banks failed in a few months, factories closed, 169 railroads failed, multitudes of hungry unemployed rioted in streets of large cities; receivers appointed for several railroads, money was hoarded and small bills sold at a premium, twice as many were unemployed (per thousand of population) as are unemployed today.

1907 Stock market collapsed after boom similar to that of 1928 and 1929, call money loaned at 100 per cent, millions of unemployed, bank and business failures were everyday incidents, president of the great Knickerbocker Trust committed suicide.

1921 Great depreciation in stock prices, frequent failures, deep gloom and pessimism for the future, manufacturers and merchants and consumers buying only what was absolutely necessary, millions out of work.

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JULY 15, 1932

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CANNON Towel No. 770 (pictured below) was born of hardy stock. In every fiber of its being ran the finest long-staple cotton. It promised exceptional longevity (a family characteristic) and its fluffy, thirsty, sturdy body assured a lifetime of real service.

In 1929, No. 770 was selling at a bargain price—lower than any other towel in its class.

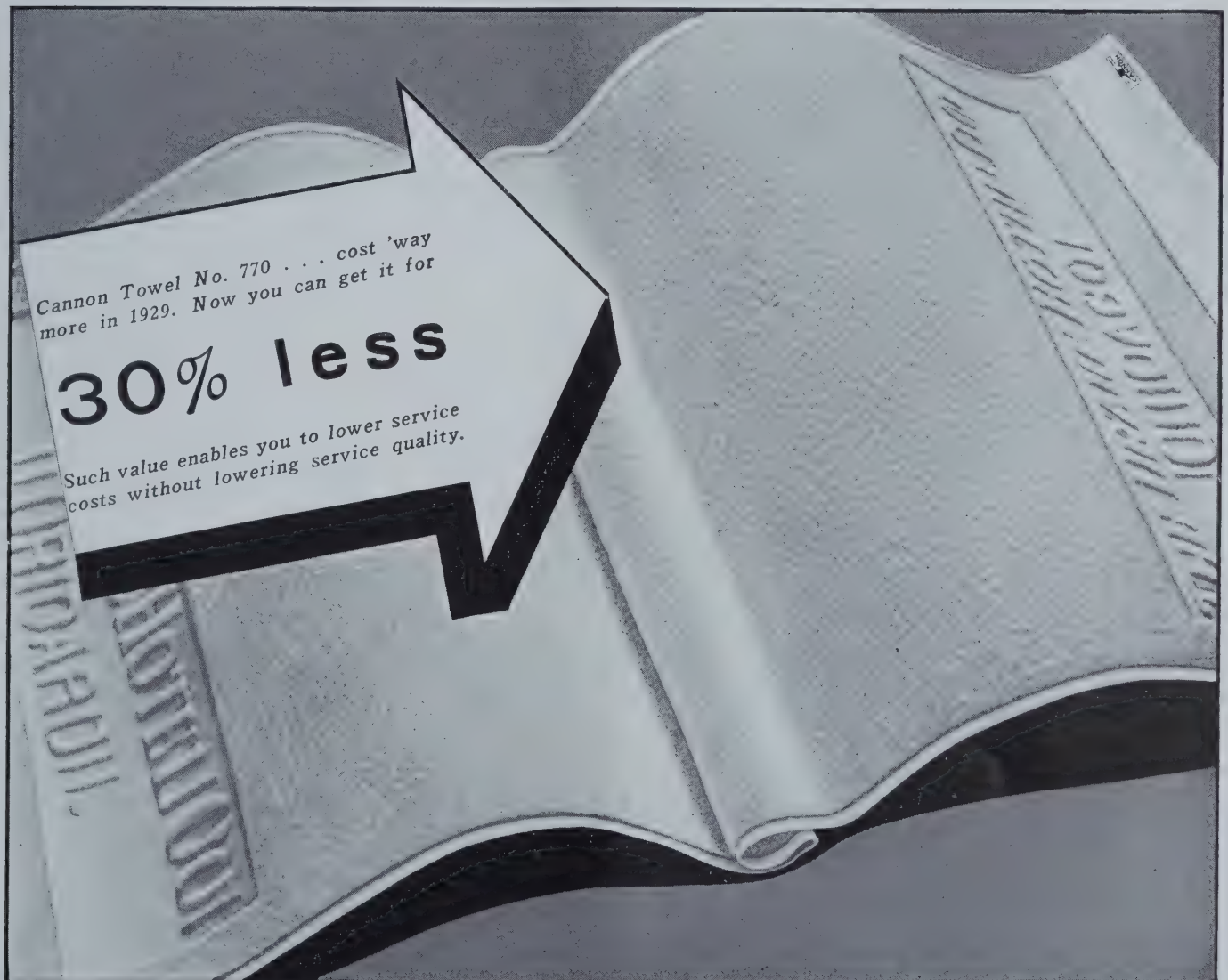
Came 1931. The costs of cotton and other raw materials reached their lowest ebb in thirty years. Now, in 1932, this same Cannon towel is selling for *thirty per cent* less than its low-down 1929 price!

And of course in three years' time, little ways were

found in which this towel—and every other towel in the Cannon line—could be made still better, promising a still *longer, more* satisfactory service-life.

If you've waited for the bargain of bargains before you renewed your present linen supply, your waiting is at an end. Let your jobber show you this super-value and all the other extraordinary buys in the Cannon line—*now*. . . Cannon Mills, Inc., 70 Worth Street, New York City. World's largest producers of towels and sheets.

Cannon towels are manufactured in accordance with Simplified Practice Recommendations No. 119-31 U. S. Dept. of Commerce Bureau of Standards.



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BUYER'S GUIDE TO HOSPITAL EQUIPMENT AND SUPPLIES — Cont'd

PROJECTING MACHINES Spencer Lens Co. Carl Zeiss, Inc.	SELF-CLOSING RECEPTACLES Solar-Sturges Mfg. Co.	SUCTION, ETHER APPARATUS C. M. Sorensen Co., Inc.	THERMOSTATS Johnson Service Co.
RADIO EQUIPMENT Samson Electric Co. Western Electric Co.	SERVICE WAGONS Swartzbaugh Mfg. Co.	SURGICAL BINDERS Marvin-Neitzel Corp.	TILE, FLOOR Congoleum-Nairn, Inc.
RANGES, KITCHEN Edison G. E. Appliance Co. Standard Gas Equipment Corp.	SHEETS AND PILLOW CASES Cannon Mills, Inc. Johnson & Johnson Utica Steam & Mohawk Valley Cotton Mills	SURGICAL DRESSINGS American Hospital Supply Corp. Bay Co. Griswoldville Mfg. Co. Johnson & Johnson Lewis Mfg. Co.	TOASTERS, AUTOMATIC Waters-Genter Co.
RECEPTACLES Solar-Sturges Mfg. Co.	SHOWER REGULATORS Powers Regulator Co.	SURGICAL INSTRUMENTS Bard-Parker Co., Inc. Meinecke & Co. Carl Zeiss, Inc.	TOWELS Cannon Mills, Inc.
RECORD SYSTEMS Hospital Standard Pub. Co. Physicians' Record Co.	SHROUD COVERS Aatell & Jones, Inc.	SUTURES Am. Hosp. Supply Co. Davis & Geck, Inc. J. A. Deknatel & Son, Inc. Johnson & Johnson Lewis Mfg. Co. Meinecke & Co. Will Ross, Inc. Stanley Supply Co.	TRAY CARRIERS Swartzbaugh Mfg. Co.
REFRIGERATION, ELECTRIC Kelvinator Corp.	SIGNAL AND CALL SYSTEMS Holtzer-Cabot Elec. Co. Western Electric Co.	SYRINGES Am. Hospital Supply Corp. Becton, Dickinson & Co. Meinecke & Co.	TRAY COVERS Aatell & Jones, Inc. Milwaukee Lace Paper Co.
REGULATORS, VALVE Linde Air Products Co.	SOAPS Colgate-Palmolive-Peet Co. Johnson & Johnson Procter & Gamble Co. John Sexton & Co.	TEA Continental Coffee Co.	UNIFORMS Marvin-Neitzel Co. Henry A. Dix & Sons Corp. Snow White Garment Mfg. Co. Will Ross, Inc. Women's Uniforms, Inc.
ROLLING WINDOW SCREENS Rolscreen Co.	SOAP DISPENSERS Aatell & Jones, Inc. Colgate-Palmolive-Peet Co. Procter & Gamble Co.	TELEPHONE SYSTEMS Western Electric Co.	WALL COVERING Congoleum-Nairn, Inc.
RUBBER GOODS Am. Hospital Supply Corp. Central Scientific Co. Meinecke & Co. Will Ross, Inc. Stanley Supply Co.	SODA, LAUNDRY J. B. Ford Co. John Sexton & Co.	TEMPERATURE REGULATION Johnson Service Co. Powers Regulator Co.	WARDROBES Stanley Supply Co.
RUBBER SHEETING Johnson & Johnson Henry L. Kaufmann & Co. Lewis Mfg. Co. Meinecke & Co. Will Ross, Inc. Stanley Supply Co.	SPUTUM CUPS Aatell & Jones, Inc. Johnson & Johnson Meinecke & Co. Will Ross, Inc.	THERMOMETERS Am. Hosp. Supply Co., Inc. Becton, Dickinson Co. Central Scientific Co. Meinecke & Co. Will Ross, Inc. Stanley Supply Co.	WASTE RECEPTACLES Solar-Sturges Mfg. Co.
SANITARY NAPKINS Griswoldville Mfg. Co. Johnson & Johnson Lewis Mfg. Co.	STEAM TABLE INSETS, CHINA Hall China Co.	X-RAY APPARATUS Gen. Elec. X-Ray Corp. Meinecke & Co. Stanley Supply Co.	WATER STILL American Sterilizer Co. Central Scientific Co.
SANITARY PAPER PRODUCTS Aatell & Jones, Inc.	STEAM TRAPS Monash-Younker Co. Powers Regulator Co.	X-RAY FILMS, SUPPLIES General Electric X-Ray Corp.	
SCIENTIFIC APPARATUS Spencer Lens Co.	STERILIZER CONTROLS American Sterilizer Co. A. W. Diack Powers Regulator Co.		
SCREENS, WINDOW Rolscreen Co.	STERILIZERS American Sterilizer Co. Central Scientific Co. Wilmot Castle Co.		

TEMPERATURE AND HUMIDITY CONTROL SINCE 1885



TIME *The Only Test That Tells*

Forty-seven years of temperature and humidity control puts The Johnson System definitely ahead and in first place. Enduring for that very long time is significant. That many years of experience is a basis best assuring reliability. That many years have furnished an invaluable fund of knowledge and experience for producing accurate and reliable apparatus for the control of temperature and humidity, and for the installation of efficient systems. The Johnson System is far beyond the experimental period. When the Johnson System is installed certainty of desired results, with permanence in efficiency and service, is assured. The time for consideration of temperature control merit is before purchase; the real test is after installation . . . which is always met successfully by Johnson apparatus.

JOHNSON SERVICE COMPANY, Milwaukee, Wis.

Albany	Cincinnati	Greensboro, N.C.	Philadelphia	Seattle
Atlanta	Cleveland	Indianapolis	Pittsburgh	Calgary, Alta.
Baltimore	Dallas	Kansas City	Portland	Montreal, Que.
Boston	Denver	Los Angeles	St. Louis	Winnipeg, Man.
Buffalo	Des Moines	Minneapolis	Salt Lake City	Toronto, Ont.
Chicago	Detroit	New York	San Francisco	Vancouver, B. C.

The All-Metal System, The All-Perfect Graduated Control of Valves And Dampers. The Dual Thermostat (Two Temperature) Or (Night And Day) Control, Fuel Saving 25 to 40 per cent.

ST. LUKE'S, Kansas City . . . In St. Luke Hospital, Kansas City, Missouri, 125 Johnson Room Thermostats control 160 radiators. The thermostats, in general, are set at 70 degrees: with some set higher or lower in accordance with individual rooms' and departments' special requirements. The temperature throughout this hospital is kept constant—automatically, without any manual attention, and regardless of outdoor weather and changes . . . Keene & Simpson . . . Architects.

BOSTON LYING-IN HOSPITAL . . . In the Boston Lying-In Hospital Johnson apparatus is applied to the hot water service system, maintaining the hot water supply uniformly at the temperature demanded. Also, the room temperatures in the wards and nurseries are Johnson Controlled by wall thermostats operating the valves of the radiators. And in addition special Johnson apparatus is included for controlling the special heat and the humidity required in the premature nursery . . . Coolidge & Shattuck . . . Architects . . . Lynch & Woodward Co., . . . Contractors.

JOHNSON SERVICE

AD-venturing

They cost less ultimately than ordinary rubber sheeting. Give absolute mattress protection! Cannot wrinkle or crack! Eliminating the usual discomforts patients are subjected to. For rigid economy and humane performance equip your beds with the original Norinkle rubber sheets. Page 51.

* * *

Are your digitalis ampuls assayed in cat units? "We prefer the cat unit," said so many cardiologists so definitely that Roche responded by adopting the cat unit method of digitalis assay. Thus the new 2.1 cc. ampuls containing Digalen Injectable (N. N. R.) are the 'only digitalis ampuls we know of, the potency of which is declared in terms of cat unit: "Total content of ampul (2.1 cc.)—1 cat unit (cir. 150 frog units)." There is no ambiguity in such a statement, and you can accept it as a definite guide for dosage whether the remedy is employed for maintenance or for quick digitalization. Page 53.

* * *

Tissues Cut, Stained and Mounted in 1½ minutes. That is one definite reason why the Spencer automatic laboratory microtome No. 880 is so popular for hospital work. Sections may be cut, stained and mounted in one and one-half minutes from the time the tissue is placed on the freezing plate. Page 55.

* * *

Best for three purposes: Preparation—Hall China assures thorough, even baking and purity of flavor. Service—Hall China adds to the attractiveness of the dish, permits full-flavored goodness and keeps hot food and beverages hot. Storage—Hall China retains freshness, eliminates staining, prevents spoilage, and, as a result, effects sizable savings. Second Cover.

* * *

The American aeroflush bedpan washer and sterilizer—utilizes most effective washing principle known—sterilizes with live steam—functions with simplest known requirements—meets most exacting plumbing code—odors do not escape—porcelain enamel body does not stain—chamber is automatically aerated. Page 47.

* * *

"We are returning six of these uniforms to show how well they have withstood the laundry. We are very well satisfied with these uniforms as they already have given us two and

Advertisements are being read more closely now than ever before and for this reason manufacturers and sales organizations are trying to convey more practical and helpful information through their advertisements than at any previous time. Here are some excerpts from messages to hospital executives that are carried in the advertising pages of this issue.

one-half years' service." The above statement, which proves SnoWhite's low cost-per-year, is taken from a letter received from a hospital which, several years ago, adopted SnoWhite Tailored Uniforms for its student nurses. Page 49.

* * *

The Stanley Thermometer Rack is a step forward in modern hospital technique because it assures greater protection for the patient. Its all metal construction permits of thorough sterilization. A frosted patch on each tube upon which patient's name or number may be written identifies the thermometer, thus reducing the chances of confusion and the danger of infection. Page 47.

* * *

Announcing \$1,000,000 credit to the Hospitals of America. With superintendents and with members of managing boards of eastern and middle western hospitals, the president of the Marvin-Neitzel Corporation has just completed a revealing investigation of hospital needs. Our success depends upon the prosperity of these institutions. Their loyalty has built our leadership. To them we now say, "Let us help you to carry on."

In active proof of our confidence in our Nation and its hospitals, we are immediately placing \$1,000,000 credit at the disposal of the hospitals of the United States. Page 2.

* * *

Forty-seven years of temperature and humidity control puts The Johnson System definitely ahead and in first place. Enduring for that very long time is significant. That many years of experience is a basis best assuring reliability. That many years have furnished an invaluable fund of

knowledge and experience for producing accurate and reliable apparatus for the control of temperature and humidity, and for the installation of efficient systems. Page 7.

* * *

Castle sterilizers are installed in many of the finest hospitals in the country. They could get there only through downright quality. And equally significant is the fact that a great majority of these hospitals have turned to us, year after year, for such additional equipment as their expansion programs required. Repeat orders are sound evidence of performance. Page 1.

* * *

Don't think your patients don't know the difference between Palmolive and ordinary soaps! The overwhelming popularity of this soap proves millions know Palmolive is made with olive oil. Page 11.

* * *

This new storage file solves the problem of storing patients' charts economically. Lowers the cost of storing to less than half a cent per chart. It will hold 50 average 8½ by 11 charts. Page 53.

* * *

Cleaning, of course, is a never-ending job. Yet there is no necessity for a condition where, only a few hours after cleaning, the surface is again grimy in appearance. This condition is almost always due to the presence of invisible grease films which collect dust. But surfaces cleaned with Wyandotte Detergent stay clean over unusually long periods of time because Wyandotte removes all grease films which may be present, and itself contains no grease. Page 14.

* * *

No one material serves more useful purposes in the hospital—more economically—than Cellucotton absorbent wadding. The ready-made convenience and low cost of Kotex, Celluwipes, and Ready-cut cellucotton absorbent wadding is undeniably demonstrated by the thousands of hospitals now using these cellucotton products. Fourth cover.

* * *

Zobec dressing rolls have become a standard material in leading hospitals on their merits. They afford (a) economy and convenience in the preparation of dressings; (b) quick absorption and unusual softness in the dressings themselves. This dressing material is Filmed Gauze—an original Johnson & Johnson development—absorbent gauze with each layer filmed with equal weight absorbent cotton. Third cover.

D&G Sutures

ARE ACCURATE IN SIZE



OVERSIZED and inaccurately gauged sutures are misleading to the operator and sometimes cause post-operative difficulties. In the laboratories of Davis & Geck, Inc. precision methods of gauging sutures have always been employed. Uniformity is assured by calibrating each strand at three points, and the size is accurately stated on each label.

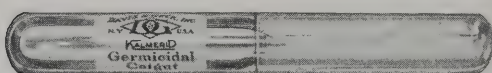
D&G Kalmerid Catgut is prepared in two varieties: Non-boilable and Boilable. Both are heat sterilized, are strong, and embody all the essentials of the perfect suture. The non-boilable variety is particularly recommended to those desiring a heat sterilized suture of extreme flexibility.

DAVIS & GECK, INC. ▾ 217 DUFFIELD ST. ▾ BROOKLYN, N. Y.

D & G Sutures - DESCRIPTIVE PRICE LIST

Kalmerid Catgut

GERMICIDAL. Exerts a bactericidal action in the suture tract. Supersedes the older unstable iodized sutures. Impregnated with the double iodine compound, potassium-mercuric-iodide. Heat sterilized.



The boilable grade is unusually flexible for boilable catgut; the non-boilable grade is extremely flexible.

TWO VARIETIES

BOILABLE NO.	NON-BOILABLE EXTREMELY FLEXIBLE
1205.....PLAIN CATGUT.....	1405
1225.....10-DAY CHROMIC.....	1425
1245.....20-DAY CHROMIC.....	1445
1285.....40-DAY CHROMIC.....	1485

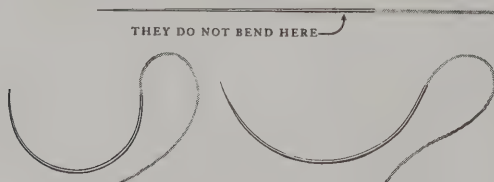
Sizes: 000 . . 00 . . 0 . . 1 . . 2 . . 3 . . 4

Approximately 60 inches in each tube

Package of 12 tubes of a size \$3.00

Intestinal Sutures

WITH Atraumatic Needles integrally affixed to 20-day Kalmerid catgut. For gastro-intestinal work and membranes where minimized trauma is desirable.



NON-BOILABLE (*Extremely Flexible*)

NO.	SUTURE LENGTH	DOZEN
1541..STRAIGHT NEEDLE.....	28.....	\$3.00
1542..TWO STRAIGHT NEEDLES...	36.....	3.60
1543.. $\frac{3}{8}$ -CIRCLE NEEDLE.....	28.....	3.60
1545.. $\frac{1}{2}$ -CIRCLE NEEDLE.....	28.....	3.60

BOILABLE

1341..STRAIGHT NEEDLE.....	28.....	\$3.00
1342..TWO STRAIGHT NEEDLES...	36.....	3.60
1343.. $\frac{3}{8}$ -CIRCLE NEEDLE.....	28.....	3.60
1345.. $\frac{1}{2}$ -CIRCLE NEEDLE.....	28.....	3.60

Sizes: 00 . . 0 . . 1

In packages of 12 tubes of a kind and size

DISCOUNT ON QUANTITIES

Kal-dermic Skin Sutures

"IDEAL FOR DERMA-CLOSURE"

A NON-CAPILLARY, heat sterilized suture of unusual flexibility and strength. It is uniform in size, non-irritating, and of distinctive blue color. Boilable.



NO.	INCHES IN TUBE	DOZEN
550..WITHOUT NEEDLE.....	60.....	\$3.00
852..WITHOUT NEEDLE.....	20.....	1.50
954..WITH $\frac{1}{2}$ -CURVED NEEDLE...	20.....	2.40

Sizes: 000 00 0
(FINE) (MEDIUM) (COARSE)

In packages of 12 tubes of a kind and size

Kal-dermic Tension Sutures

(Identical in all respects to Kal-dermic skin sutures but larger in size.)

NO.	INCHES IN TUBE	DOZEN
555..WITHOUT NEEDLE.....	60.....	\$3.00

Sizes: 1 2 3
(FINE) (MEDIUM) (COARSE)

In packages of 12 tubes of a kind and size

Kalmerid Kangaroo Tendons

CHROMICIZED to resist absorption for approximately thirty days.

NO.	
370.....	NON-BOILABLE GRADE
380.....	BOILABLE GRADE

Sizes: 0 . . 2 . . 4 . . 6 . . 8 . . 16 . . 24

Each tube contains one tendon
Lengths vary from 12 to 20 inches

Package of 12 tubes of a size \$3.00

Obstetrical Sutures

A 28-INCH suture of 40-day Kalmerid germicidal catgut, size 3, threaded on a large full-curved needle. Boilable.

No. 650. Package of 12 tubes . . . \$3.60

Other D & G Products

INFORMATION covering unabsorbable sutures, short sutures for minor surgery, circumcision sutures, emergency sutures with needles, will be sent upon request.

DAVIS & GECK, INC. - 217 DUFFIELD ST. - BROOKLYN, N. Y.

D & G Sutures are obtainable from responsible dealers everywhere; or direct, postpaid

Survey of Hospital Spurs Interest in Equipment

HOSPITAL MANAGEMENT recently received inquiries for booklets and other material listed in this column from three different executives of a hospital in a mid-western city. Apparently all of the inquiries had originated without knowledge that others in the same hospital had sought material also. Inquiry developed that a business men's organization had made a survey of the hospital and had suggested certain changes and modernization in some departments. The moral is, of course, that nobody should wait until a survey is made before finding out what manufacturers have in the way of new items. HOSPITAL MANAGEMENT will gladly have you supplied with any of the booklets, etc., listed herewith.

Anaesthetics

No. 344. "Puritan Gas News," a publication of interest to all connected with anesthesia, gases, oxygen therapy, etc. Published by Puritan Compressed Gas Corporation. Contains many helpful hints for the anesthetist and others. 532

No. 290. "Suggested precautions in the use of ether, ethylene and other anesthetics." Puritan Compressed Gas Corp. c30.

No. 347. "Recent Trends in Oxygen Therapy," a valuable brochure on the subject of oxygen as a therapeutic agent. Well prepared and published by Linde Air Products Company. 532

Cleaning Preparations, Soaps, Etc.

No. 326. "The story of soap," an intensely interesting booklet telling in story and pictures of the making of soap and soap products. Unusually well illustrated. The Procter & Gamble Co.

Beds, Mattresses

No. 345. "The Story of Slumberon, the Mattress Luxurious." An interesting and attractive folder describing the construction of Slumberon mattresses, and explaining its unusual features. The Rome Co., Inc. 532

Cubicle Equipment

No. 337. "Privacy in the Modern Hospital" is the title of a valuable booklet on cubicle screening published by H. L. Judd Co. After outlining the problems involved in securing privacy for ward patients, the booklet works out concrete solutions for many problems. c32

Disinfectants

No. 342. A table showing the amount of Lysol disinfectant and water necessary to make solutions of various strength, together with a description of the correct solutions to use for various purposes in the hospital. Also a dilution chart for use in the laundry. Lehn & Fink, Inc. 532

Flooring

No. 334. "Resilient Floors," an interesting photograph album showing Sealex floors designed and laid in recent years. Also contains a description of the many types of Sealex floors. Congoleum-Nairn, Inc. 232

General Equipment, Furnishings and Supplies

No. 327. Booklet describing professional uniforms for nurses and others, published by Henry A. Dix & Sons Corp. b0

No. 284. "Modern Ideas About Towels." Cannon Mills, Inc. b0

No. 261. "Nurses' Apparel and Hospital Supplies," a 32-page catalog. Marvin-Neitzel Corp.

No. 341. "SnoWhite Tailored Uniforms," and "SnoWhite Tailored Uniforms for Student Nurses," two booklets describing the complete uniform line of Sno-

White Garment Manufacturing Company. Each style is well illustrated and completely described. 532

No. 323. "Standard ready dressings and supplies for hospitals," a folder showing the styles, types and sizes of ready made products. Johnson & Johnson.

No. 328. "Curity Ready Made Dressings Manual," an interesting manual showing the complete line of ready made dressings, with descriptions of uses and other informative material. Lewis Mfg. Co. L31.

No. 329. The 1932 catalog of Will Ross, Inc. Attractively printed, well arranged catalog of the complete line of hospital equipment and supplies. L31.

No. 333. Numerous interesting booklets and pamphlets describing the therapeutic effects, the method of manufacture, and medical history behind many "Roche" drug products. Hoffmann-La Roche, Inc. 232

No. 336. "Cotton, Gauze and Adhesive Plaster—Their Manufacture and Application in Surgery," an exceptional booklet of 96 pages containing much interesting material on these subjects for hospital executives, staff members, nursing students, etc. Published by Johnson & Johnson. c32

No. 339. "Kalmerid Germicidal Tablets," a pocket-size leaflet describing the composition, efficiency and uses of this new product. Davis & Geck, Inc. 432

No. 340. A complete series of pamphlets, many of which, such as "The Mystery of Sleep," "Why the Cat Unit?" and "When Chemists Turned from Gold to Drugs," are especially useful in teaching materia medica to student nurses. Available in any quantity. Hoffman-La Roche, Inc. 432

No. 314. "How to Obtain Maximum Service from Hypodermic Needles and Syringes," an interesting, pocket size manual on the selection of needles and syringes for each kind of service. Also contains practical information on how to sterilize, clean, and care for these instruments. Becton-Dickinson Company.

No. 332. Bulletin No. 260, describing the Powers thermostatic radiator valve, a self-operating regulator designed for vacuum or vapor steam heating systems. The Powers Regulator Co. 132

Kitchen and Food Service Equipment

No. 331. "Good Coffee," a monthly publication of interest to all quantity users of coffee. Published in newspaper style and containing many hints valuable in the preparation of coffee. Continental Coffee Co., Inc. 132

No. 300. "The Perfect Tray," by Helen E. Gilson, Onandaga Pottery Co. d0

No. 276. Modern Kitchens. A 70-page booklet. International Nickel Company. C30

No. 252. "Scientific Hospital Meal Distribution." Swartzbaugh Mfg. Co., Toledo, O.

Laundry Equipment and Supplies

No. 277. Laundry Owners' Year Book. International Nickel Company, Inc. C30

Sutures and Ligatures

No. 338. "The Bacteriological Control of D. & G. Sutures," an interesting pocket-size folder describing the various manufacturing processes of sutures. Davis & Geck, Inc. 432

Sterilizers, Stills

No. 234. "American Sterilizers and Disinfectors." Catalog. American Sterilizer Company, Erie, Pa.

No. 213. "Sterilizing Technique Series." Five booklets. Wilmot Castle Company.

Surgical Instruments and Supplies

No. 322. "Handbook on Ligatures and Sutures," 1931 edition. An interesting booklet on the history, preparation, handling and use of ligatures and sutures, completely revised. Johnson & Johnson.

Trends in Nursing School Administration, as Hospitals See Them—Should Superintendents Be Licensed?

WE have made one or two important modifications of our policy as it concerns the school of nursing. We now state in our contract that it is understood and agreed that the student at any time, without cause or explanation, may by resignation terminate her connection with the hospital (this has always been her privilege), and the hospital, on its part, at any time, without cause or explanation, but on 30 days' written notice, may terminate the student's connection with the hospital. The real purpose of this new feature is to make it possible for us to reduce our expenses in the presence of a financial crisis.

Also, we stated that any preliminary student who voluntarily withdraws from the preliminary class of St. Luke's Hospital any time during the preliminary period will be expected to reimburse the hospital, partially or wholly, in the amount of the cost of maintenance of the preliminary student during the time she has been in the institution. It is the experience of all schools, I presume, that young women enter the preliminary class with no very serious intention of continuing in the school, and since these students return nothing to the institution, but cost a considerable sum, it seems only fair if they withdraw from the institution during this period that they should pay the cost of their maintenance.

We have just finished making a study of the cost of maintaining and educating a student nurse, and find that it costs \$409 to maintain and educate each student nurse per year, or \$1,227 for three years.

The value of the student nurse increases, other things being equal, as her experience enlarges and as she completes period after period and

The nursing school is the subject of deep consideration by hospital executives today and opinions of others are eagerly sought after by heads of institutions which contemplate a change in their nursing school policies. These comments supplement those which appeared on page 12 of the June issue of "Hospital Management."

The editorial board will be glad to comment on any question or to give specific information, based on experience, in regard to any matter presented to it by any reader.

year after year of her training. There comes a time then when she is perhaps as valuable to the institution as a graduate nurse. If the salary of a graduate nurse is \$100 per month, then the value of the student nurse expressed in dollars is \$100 per month when she has almost completed her course, i.e., the value of the student nurse may be one-third, one-half, two-thirds, three-fourths, and finally quite equal to the graduate nurse. If the institution has a number of senior students who have almost arrived at the time in their training when they are as valuable as graduate nurses, it is very fortunate.

The study which we are submitting to the State of Ohio, Department of Nursing, for the calendar year 1931 shows that our present plan of providing nursing service is

about \$94,600 a year cheaper than the employment of graduate nurses.
—C. S. WOODS, M. D.



FOR more than six years we have required high school graduation and that the student should have received 72 academic counts. Some high schools will graduate students with 67 and 67½. Beginning with this fall, we not only require four years of high school, but student must be in the upper third of her class.—C. S. PITCHER.



THE suggestion occasionally referred to in HOSPITAL MANAGEMENT that hospital superintendents be licensed by states or in some other way be identified in regard to their ability does not appeal to me. I do not see that any particular benefit would be derived from such a practice.

Most states which would have an examining board would undoubtedly include on the board people of insufficient experience in the management of hospitals; furthermore, it is a foregone conclusion that politics would enter. I believe that the further the hospitals keep from the politics the better.

Why should a board of trustees which is responsible for the operation of a hospital have its hands tied in regard to the person it may employ?

Finally, it seems to me that licensing would be very detrimental and would tend to make the splendid men and women who serve as trustees feel that their judgment was not good and that some of their prerogatives were being taken away. Therefore, I do not favor licensing by states.—W. W. RAWSON.



OLIVE OIL—famed for beauty results

This much goes into every cake of Palmolive →

DON'T think your patients don't know the difference between Palmolive and ordinary soaps! The overwhelming popularity of this soap proves millions know Palmolive is made with olive oil. The actual size, six-inch test tube at the right shows just how much olive oil goes into every cake.

Other soaps—they rarely even tell what they are made of. But Palmolive is proud of its ingredients—shows them to you. No wonder more than 20,000 beauty experts

both here and abroad urge the use of this one soap. Palmolive in your hospital shows patients you are considerate of their beauty needs.

In spite of its quality and prestige, Palmolive costs no more than ordinary soaps. Your hospital's name printed on the wrappers with orders of 1,000 cakes or more. We will gladly send you prices of our five special sizes for hospitals. The coupon will also bring you our new free building cleanliness booklet. Mail it today!

COLGATE-PALMOLIVE-PEET COMPANY

Palmolive Building, Chicago

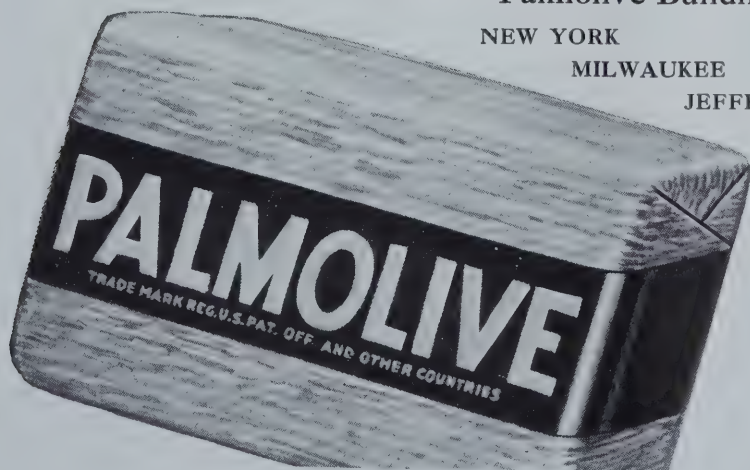
NEW YORK

KANSAS CITY

MILWAUKEE

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HOSPITAL NEWS
537 South Dearborn Street
CHICAGO - - ILLINOIS

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part.

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A Page of Letters to the Editor

IS TRAINING NEEDED?

Editor, HOSPITAL MANAGEMENT: In the past several issues of HOSPITAL MANAGEMENT there have been many letters, editorials and comments on training hospital superintendents and the need for trained superintendents. This letter is intended to present another aspect of the situation—one which is much more serious and pertinent. About two years ago my contract as superintendent was not renewed, although the board expressed to me and to many others complete satisfaction with my work. For fifteen months I tried all of the usual channels to locate a job. My credentials were sufficiently good and twice I was chosen as alternate from seventy-five or more applicants.

Finally I went to Chicago and saw Dr. Caldwell of the A. H. A. He informed me that the association had on file the names of at least 150 superintendents of ten years or more experience who were looking for locations! Does this indicate a need for more experienced superintendents?

This spring, after an absence of two years from the field and believing that a period of training would be beneficial, I took a selected list of hospital administrators who have voiced their favorable opinion on the subject of training superintendents. To this list I addressed a brief, concise letter of explanation and application. Each replied promptly and courteously, but not one could offer a helpful suggestion!

Do you wonder that I read the articles on this subject with my "tongue in my cheek"?

In the meantime and with employment conditions as they are, my long association in the hospital field has certainly not helped my applications for other work. Six years were spent as a student superintendent and covered organization, policies, accounting, construction and funding, and six more in successful administration.

Certainly this is a personal history, but I'll venture that with slight variations it fits a goodly portion of the 150 mentioned by Dr. Caldwell.

And so I ask, who is willing to offer training? What shall become of the trained men and women now available? How does one go about it to put his training to practical use? Why do so many of the supporters of the training idea pass the buck when an opportunity to serve is given them?

What is your candid opinion? I shall really appreciate your comments or advice, or both.—"UNEMPLOYED."

TISSUES AND SALARIES

Editor, HOSPITAL MANAGEMENT: Lately there has been a question in my mind regarding the subject of tissue. I have been wondering if it were permissible for one member of the staff to examine a section of tissue removed by another surgeon without the latter's permission or the permission of the hospital superintendent? Are laboratory specimens open to the examination of any or all staff members?

I very much appreciate the help you have previously given me. I have used

HOSPITAL MANAGEMENT articles for press and magazine articles.

There is also another problem confronting me, about which I should appreciate any help you might be able to give. It is the question of a wage schedule. Several of the supervisors are receiving so much higher a salary than others in comparison to the work involved. For example:

The operating room supervisor draws a salary of \$130 per month, with full maintenance. She does nothing but have charge of the operating room, which averages 150 operations a month.

The anesthetist draws \$125 per month with full maintenance and has no classes.

The surgical floor supervisor also receives \$125 per month with full maintenance. She relieves in the operating room and also gives anesthetics when necessary.

The obstetrical supervisor's salary is \$95 per month with full maintenance. She teaches two subjects.

The medical supervisor teaches one subject and receives \$85 per month with full maintenance.

The dietitian receives \$100 per month with full maintenance, has full charge of the kitchen, does the buying of meats and groceries, and teaches.

The pediatric supervisor receives \$95 per month, full maintenance. She teaches three subjects.

The instructress teaches 18 hours a week, has every other Sunday off, and receives \$110 a month with full maintenance.

We have two laboratory technicians and one X-ray technician. The latter receives \$65 a month, full maintenance, while one technician receives \$110 and the other \$95, both having full maintenance.

I might state that some of the supervisors have been with this institution for eight years. Regardless of the length of time in service, I believe that some adjustment should be made in salaries even if times were not as they are.—EASTERN SUPERINTENDENT.

ANY COMMENTS?

[Note: The following are excerpts from three letters received within a week from superintendents who have "resigned." For obvious reasons, names are omitted.]

"One of the trustees who was president of a bank which no longer exists will act as superintendent for an indefinite period."

"I have been released to make room for an intimate friend of one of the directors."

"The president has been aspiring to my position. He has made things very unhappy for me. I am told he expects to take charge shortly."

HOSPITAL WATER RATES

Editor, HOSPITAL MANAGEMENT: During the tri-state convention in Chicago the subject of the city furnishing privately owned hospitals with light and water during these trying conditions was brought up. Would you give me the names of some hospitals which are receiving this aid from their city?—ILLINOIS SUPERINTENDENT.

WANTS TRAINING

Editor, HOSPITAL MANAGEMENT: Please advise if you know of a hospital or institution that gives a course in hospital management.

For the last year I have been business manager for a small hospital and like the work very much and would like some special training along this line as I would like to continue in the work. I have had six years' experience as bookkeeper in addition to my year's work in the hospital. I have had two years accounting at a university and one year in commercial law.

I find HOSPITAL MANAGEMENT very helpful in my work and enjoy it very much.

SOUTHERN EXECUTIVE.

A BIG ORDER

Editor, HOSPITAL MANAGEMENT: I would appreciate it if you could supply me with all the hospital information possible for a new hospital building to be built.

MEXICAN ARCHITECT.

"SIT TIGHT!" SAY WE

Editor, HOSPITAL MANAGEMENT: I feel that I have been with this hospital long enough and would like to obtain a position elsewhere. There is no particular hurry, but I am writing you about my plans and am asking you kindly to keep me in mind if you should hear of a suitable vacancy. I would not want to go to a smaller hospital, in fact, I believe that my experience entitles me to serious consideration in the event a larger hospital may need a superintendent.

VETERAN.

IS THIS A CHALLENGE?

Editor, HOSPITAL MANAGEMENT: I believe it is possible to reduce expenses of the dietary departments of a great many hospitals and I base this statement on experience with a number of institutions. In one large institution a material reduction in the cost per meal was made after the application of certain principles which are fairly well known to many in charge of food departments of commercial institutions. I also believe that many hospitals could easily improve the quality of their food, make the dishes more appetizing and thus reduce waste of prepared food, and at the same time operate their food service on a lower unit cost. I admit that hospital food service presents a number of difficulties and problems not found in other fields, but I still maintain that many hospitals can reduce their food budget.

FOOD CONTROLLER.

WILL YOU COOPERATE?

Editor, HOSPITAL MANAGEMENT: We are interested in securing list of rates of various hospitals, particularly for X-ray pictures, laboratory tests, routine and special fluoroscopic examinations, physical therapy, diathermy treatment, and also operating room charges. If you can help us in this matter we shall certainly appreciate it.

SISTER MARY, R. N.,
Superintendent, Holy Name Hospital,
Gadsden, Ala.

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Cleaning, of course, is a never-ending job. Yet there is no necessity for a condition where, only a few hours after cleaning, the surface is again grimy in appearance. This condition is almost always due to the presence of invisible grease films which collect dust.

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HOSPITAL MANAGEMENT

A Practical Journal of Administration



Systematic, Friendly Follow-Up Helps Reduce Unpaid Balances

Inserts and Leaflets Bearing on Collections, Prepared by Experts, Valuable Aids to Collection Department; Definite, Conservative Agreement on Schedule of Payments Held Essential

By JOHN E. LANDER

Financial Secretary, Wesley Hospital, Wichita, Kan.

EITHER before, or as soon as possible after admission, it should be definitely decided whether the payer can and will pay in full or in part or whether the case will be handled as free service. The financial ability of the payer, or his relatives and friends, is a factor to be taken into consideration in arriving at a fair and reasonable conclusion.

It is wise and, in many instances, possible, to have an understanding regarding payment on "discharged unpaid" accounts before the time of dismissal so the matter can be rather quickly disposed of at that time.

However, in every instance where terms of payment have been granted, the fact of a *conservative agreement* should be stressed so that after an arrangement has been made, it is reasonable to believe that the contract for payment can and will be carried out.

Among other things on a card of rules which should be on the back of the door in each room in the hospital there should appear the following information:

PAYING THE HOSPITAL

Hospital bills should be paid weekly with final payment being made at the time of dismissal. If there is to be any exception to this rule credit arrangements should be made at the office of the Financial Secretary.

Unless terms are agreed upon, we take for granted that the payment of your account will be completed at the time of dismissal.

This is the third of a series of five articles by a man who has devoted much time and thought to the matter of hospital collections. The first article appeared in the May issue.

This article deals with methods of following up the patient who leaves the hospital without paying in full. It suggests the value of well thought out letters, sent regularly, the use of inserts, leaflets, etc., and it gives a few examples of letters which have proved effective in getting action.

The fourth article, next month, will deal with the value of membership in a local credit association and the aid that such an organization can give. It also will suggest action to be taken when the hospital is convinced that the patient is determined not to pay, although able to do so.

So, where a patient leaves the hospital with all or part of the bill unpaid, that fact presupposes a definite understanding as to how payment is to be made.

Where the patient has left the hospital and arranged terms of payment, the following letter sent a few days

later helps to further a nice friendly feeling, at the same time re-emphasize the terms of payment:

ACKNOWLEDGMENT OF CHARGE ACCOUNT
Dear Mr. Blank:

It was a pleasure for us to accept your charge account and we are anticipating a pleasant business relationship. Terms were granted as an accommodation to you and we feel that if it becomes possible for you to make larger payments than our agreement calls for, you will be glad to do so.

We are thankful for your patronage and appreciate your friendship. It is our aim to render the very best possible service at reasonable rates and you will, of course, see that each payment reaches us promptly.

Cordially yours,

P. S.—Terms were \$. . . , payable

No matter how carefully the case was analyzed financially at admission or afterward and regardless of the fact that definiteness and conservatism were emphasized, some payments will not arrive as agreed and some of the accounts will need a great deal of "follow up" and persuasion.

This article will consider the "follow up" cases as they may be dealt with by the credit department of a hospital without using outside agencies.

On the statement of Wesley Hospital a little "pull," emphasizing promptness, cooperation, confidence, stability and appreciation, is added through the following notation printed at the bottom of the sheet:

Prompt payment insures your credit and

Not Advisable to Take Notes, as General Rule, Says Mr. Lander

Here are some questions suggested by this article, and the answers by Mr. Lander. Readers are invited to discuss these articles or to ask questions regarding them.

What would you do if a patient on leaving the hospital evaded a written promise of payment?

The patient would immediately be contacted and an explanation asked. Sometimes unforeseen circumstances have arisen that make a revision of terms necessary. The main thing is to stay by the original agreement as closely as possible.

What is your practice regarding notes?

The taking of notes, generally, is not advocated. They should be taken where such procedure would help the standing of the individual case. For instance, where a farmer cannot pay "until harvest" and harvest is several months away, or where it appears that payer might fail in keeping his promise or that payer might move, or for any other reason, it would appear that a note in any way betters the situation.

When a note is not paid promptly, can you collect through a bank, or is a suit necessary?

Sight drafts can, and sometimes should, be drawn on payer through local bank, true either of note or account. If unpaid, a suit may be necessary. That phase of collections will be mentioned in article 5.

What happens if a patient leaves the hospital against advice of doctor or without his permission, and also fails to make arrangements for payment of hospital bill? Has this ever happened at Wesley?

We have few records of patients leaving without a doctor's dismissal slip having been issued. A very sick woman once felt that she must go home and cook for harvest hands. Both doctor and hospital authorities pleaded with her not to go. She insisted, so was asked to sign a statement saying she was leaving against the advice of both doctor and hospital and absolved both from any and all blame. She signed, left, and died within a week. The account was paid and no liability attached to either doctor or hospital.

Do you get 100 per cent cooperation in signing of notes where you ask for this?

We can't remember more than two or three cases where patients have refused to sign notes in the course of seven years. In the vast majority of cases, open accounts are preferable to promissory notes.

Do you always ask that a note be signed on admission?

We never do, but the admission blank is signed, and it is in the nature of a note.

helps us pay our bills when due. That is effective cooperation. It inspires confidence and stabilizes all business.

Your patronage is appreciated; your payment will be. Thank you.

.....
Credit Department.

Sometimes it is necessary to send a "late charge" letter as follows:

LATE CHARGE LETTER

Dear Mr. Blank:

Subject: Balance on your account, \$.....

By way of explanation, we would like to say that charges come into the Administration office from thirteen different departments of the hospital and sometimes a patient leaves before all charges have been posted.

Late charges coming into the office on your recent bill total \$....., for..... We are sorry about this but it is simply unavoidable in some cases.

With this explanation, nearly all of our friends, realizing that *mistakes will sometimes happen*, are kind enough to send check to balance their account.

Trusting we may hear from you soon and thanking you for the favor, we remain

Sincerely yours,

With the statement are four "inserts" constituting a series that are helpful and effective. These four inserts can be secured from Arrow

Service, Schenectady, N. Y., or other companies.

These "inserts" are copyrighted and may not be reproduced here, but they are intended to emphasize the necessity for action in making payment, and they are worded in a friendly and yet frank fashion.

Another series of four stickers can be had from C. R. Pierce, Seattle, Wash.

Wesley Hospital uses with advantage similar material from Maxwell Droke, Indianapolis, and others. It also makes good use of the printed material of the National Retail Credit Association. This is directed at the slow payer to cause him to think of the seriousness of losing his credit standing. The cash value of a good credit, the obligation of keeping a promise, the fact that a credit rating follows an individual are some of the themes of the material from the credit association which has been found effective in stimulating attention and action of slow payers.

"Tell them regularly and tell them often" might be considered the

slogan of a good collection department in the matter of getting action from a patient whose account was not paid in full on discharge. Wesley Hospital is a great believer in this slogan and as evidence the writer presents a series of three letters that were designed to speed payment during the summer:

Dear Mr. Blank:

Our first interest is always to assist and accommodate the patient and in so doing we sometimes jeopardize our own interests by our leniency in the extension of credit.

Plans are now being made looking toward payment on our mortgage and the money must be in hand *not later than July 15th*. This is necessary in order to satisfy our creditors.

We are sure your appreciation of Wesley's services and terms will prompt you to mail us check for balance of your account, \$....., at the earliest possible moment.

Please remember, *between now and July 15th*. Can we count on you?

Sincerely yours,

Dear Mr. Blank:

There is a belief which permeates the atmosphere of Wesley Hospital to the effect that everything done here should be prompted by the friendliest of feelings. This is true whether it refers to the care of patients, granting terms for the accommodation of the payer, or friendly and businesslike procedure in the collecting of accounts.

We sent you an important letter not long ago and are expecting that you will make whatever arrangements are necessary to care for your balance, \$..... *between now and July 15th*, when we must pay on our mortgage indebtedness.

The terms granted you were gladly given and we are sure you will come to our rescue now.

Appreciating your patronage and trusting this matter will receive your consideration in the very near future, we remain

Sincerely yours,

Dear Mr. Blank:

Two letters have been sent you within the last few weeks emphasizing the fact that we are expecting payment of your account, \$..... *not later than July 15th*.

Maybe you have been too busy to answer. We are, however, extremely anxious to hear from you. This is very important. Our creditors are waiting. They must be paid. We are depending upon you *not later than July 15th*.

Sincerely yours,

Here are sample letters designed to persuade a slow payer to resume payments or to send something on the account:

FOR PAYMENT OR RE-ARRANGEMENT

Dear Mr. Blank:

Your account, \$....., having run long past our regular terms has been handed me for adjustment.

We don't want to take any action that would affect your credit standing so I'm making a final plea for your co-operation. We'll be only too glad to help you straighten this matter out if you'll just meet us half way and make some definite arrangements for taking care of the account.

If you can't pay the entire account, send part of it now and a definite promise on the balance. The bottom of this letter

These Things Help to Reduce "Discharged Unpaid" Accounts

Agreement on admission or during patient's stay as to details of payment, so that delays and waiting at time of discharge will be avoided or minimized. This agreement should be conservative, to make patient's payments well within his means.

A friendly letter a few days after discharge, reminding patient of agreement and emphasizing that installment arrangement was an accommodation to him.

Prompt follow up as each installment is due, each follow up being written in a friendly fashion.

A printed note at bottom of statement urging advantages of prompt payment and expressing appreciation of hospital for patronage.

Inserts and leaflets, prepared by experts, stress need of payment in human, humorous fashion, but at same time point to value of maintaining good credit rating.

If payment is not received on time, make immediate inquiry as to reason, insisting that patient carry out his part of agreement, just as hospital has done, appealing to patient's pride and fairness.

is conveniently arranged for your reply, which will be expected by (Out of town, give ten days. In town, eight days.)

Sincerely,

Check enclosed full amount \$.....
Enclosing check for \$..... and will
pay balance

Remarks
Signature

Please fill in and return in enclosed envelope.

An account approaching an undesirable classification receives a letter like this:

Dear Mr. Blank:

We have four classes of folk on our books:

First: Those who meet their payments promptly.

Second: Those who keep on paying, but whose payments arrive irregularly.

Third: Those whose intentions were good when agreement for payments was made; but who for some reason have been unfortunate or have had unforeseen things arise which make payments very indefinite.

Fourth: Those who simply don't pay without being forced.

Although your account is past due and regardless of the fact that we have written you a number of times, we still have you placed in group three. However, if payment is not now made or if we cannot have personal arrangements with you, we must let your account go for collection.

IF THERE IS ANY REASON why payment should not be made PLEASE SEE US VERY SOON, as adjustment or compromise cannot be made after the account has left our hands.

Balance is \$.....

Very truly yours,

PLEA FOR GOLDEN RULE

Dear Mr. Blank:

When you write a courteous note to a friend—and another—and still another—and wait and wait and get no answer—what do you think?

We like to consider our patrons as our

friends. We like to feel that all our relations with them are conducted on friendly terms—whether we are rendering them service or whether we are asking for payment of their accounts.

Several friendly requests concerning your account have brought no payments. There must be some good reason. We can't believe that you are intentionally disregarding these friendly requests. But if you were in our position, what would you think?

You'd agree that we were entitled to some explanation, wouldn't you?

Sincerely yours,

SLOW CHECK LETTER

Dear Mr. Blank:

We are sorry that your check for \$..... given us on Bank, has today been returned marked

Surely someone has made a mistake for we know you would not intentionally give us a "piece of bad paper."

As members of The Wichita Retail Credit Association, we are urged to report all "slow checks" immediately. We are not doing so in this case, however, because we feel that you may have a satisfactory explanation.



Expecting to hear from you by return mail and thanking you for the favor, we are

Sincerely,

In following "discharged unpaid" accounts first, have an agreement, make it conservative, be punctual in insisting that the contract be carried out as agreed. If a payment is missed, find out immediately whether there is a reason. Appeal to the payer's pride, his fairness, his love of right, the Golden Rule, cooperation, that confidence and faith are the products of promptness and kept promises and that they bring stability to all business.

Just as soon as you feel sure the payer is unfair or that he is "stalling," inject the Credit Association into the picture. This will be the basis of the next article.

PASSES 50,000 MARK

The 50,000 mark for patients was passed in 1931 by the Babies' Hospital of the Columbia-Presbyterian Medical Center, New York. In addition the hospital has during its 44 years had 480,000 visits to its out-patient department. President John I. Downey recently paid a tribute to the personnel who, when a falling off of conditions necessitated the closing of one ward floor, accepted a 10 per cent reduction in salaries and under the difficulties of less spacious quarters carried on. The number of patients admitted during the year was 2,152, of whom 1,842 were treated in the wards. The average daily number of patients was 96.6 and the average stay was 15.6 days; 20,198 patients were treated in the out-patient department. Dr. Charles C. Hedges is superintendent, and Winifred Kaltenbach, R. N., is director of nurses.

CLEVELAND HOUSEKEEPERS

The June meeting of the Cleveland Chapter of the National Executive Housekeepers Association was held at the University Club. Mrs. E. L. Thorpe issued the invitations. Mrs. Frey, the president, introduced Martin Ribar of the Cleveland Association of the Blind. His talk was demonstrated by samples of unfinished and finished products of the broom and brush trade.

Mrs. Frey gave a report on the national banquet at New York. She was quite elated over her trip, especially over the brilliant affair that brought the housekeepers together. She also made a report of her recent trip to Pittsburgh attending a meeting of the recently formed chapter.

The summer outing and meeting of the Ohio State Association at Cedar Point July 16 is to be a two-day event.

MIMEOGRAPH REPORTS

Some hospitals which in past years have printed annual reports this year are mimeographing them. The idea of getting facts about the hospital's performance before the public in this form is to be commended, if circumstances do not permit printing. Printing, of course, is much more effective, but it would seem that a mimeographed report, condensed within a few pages, is better than not making contact with the public at all.



President Paul Fesler, American Hospital Association, visited the Democratic National Convention to get ideas for the A. H. A. convention in Detroit. There he is (right). At the left is a picture of one of the Democratic sessions, with President Fesler hardly discernible in the lower right. Dr. M. T. MacEachern was another regular visitor at Democratic sessions, remaining until 2 a. m. of that all night meeting and listening to the rest of the program over the radio at home. George A. Collins, Denver, a life member of the A. H. A., took an active part in the convention as a member of the Democratic National Committee from Colorado.

Innovations Add to Value of A. H. A. Convention

IN addition to the keynote of "Let's act on the known facts" which Paul Fesler, superintendent, Wesley Memorial Hospital, Chicago, and president of the American Hospital Association, would like to offer as the theme of the 1932 gathering at Detroit, a number of other innovations are most likely to be introduced. All are intended to make the convention of the greatest practical value to all visitors.

Profiting by the success of the Western Hospital Association, which had a session devoted to an explanation of some of the principles and details of operation of equipment by qualified representatives of manufacturers, President Fesler would like to make the final session at Detroit on Friday morning, September 16, an "equipment clinic." It has been customary for this final session to be devoted to the introduction of new officers and the transaction of routine association business and as a result the attendance has been very small. With authentic information concerning certain equipment in daily use in every hospital to be offered at this session, however, it is believed that this program alone will be worth the cost of the trip to the hospitals sending representatives, and President Fesler hopes that the attendance will be as large as any general session of the 1932 convention.

One of the most important sessions of the week will be the Thursday

evening program at which facts about the economic situation, as it relates to hospitals, will be summarized by a well qualified speaker. During the convention also an effort will be made to have each section chairman summarize the thought of his or her meeting relating to the economic situation, and it is believed that the summaries thus presented will be of special value.

A session devoted to a topic of increasing importance to hospitals will be that on hospital libraries, under the chairmanship of Miss Perrie Jones, institutional librarian, state board of control of Minnesota, St. Paul. Miss Elizabeth Reed, librarian, Massachusetts General Hospital, will be one of the speakers on this subject.

Because of the many viewpoints which will be represented by the speakers at Detroit and because of

the emphasis of the program on economic questions, the association headquarters believes that the attendance will be fully up to standard. Dr. B. W. Caldwell, executive secretary, and the A. H. A. trustees, are giving President Fesler every support in his desire to make every paper and committee report of practical value to the visitors.

The convention will get under way Monday afternoon, September 12, and in addition to the sections devoted to special types of hospitals or to hospital departments, the general meetings also will have a central theme. All topics and all committee and other activities, according to Mr. Fesler, are centered on making the field acquainted with recently found facts of such groups as the Committee on the Costs of Medical Care, Grading Committee, White House Children's Conference and other organizations, and on pointing out to the field the possible effect of these studies and indicating trends or changes of interest to hospitals.

KEEPS INFORMED

"There is no meeting ever held by the Cleveland Chapter or the Ohio Association where I do not mention regularly magazines and literature pertaining to our professional work," writes Mrs. Adele B. Frey, housekeeper, Hotel Hollenden, Cleveland, and president Cleveland Chapter, National Executive Housekeepers' Association. "I never fail to point out to our members the importance of reading those magazines to keep us posted up with our work. They mean to every one their livelihood. I am a personal subscriber of 11 different papers and magazines related to my work, and consider it a pleasant duty to read and keep posted. I also consider this the best way to keep contact."



Catholic Sisters Have Busy Time at Villanova

Religious Activities of Hospitals, Nursing and Economic Conditions Get Important Attention at Seventeenth Annual Convention; Officers Are Re-elected

By KENNETH C. CRAIN

MARKED by an interesting program, an excellent exhibit and fair attendance, the seventeenth annual convention of the Catholic Hospital Association was held at Villanova College, Villanova, Pa., June 21 to 24. The meeting was a busy one, the typical day being devoted to a general session in the morning, with three group meetings in the afternoon, and this was the routine on Tuesday, Wednesday and Thursday, there being no afternoon session Friday.

All of the officers were re-elected, as follows: President, Rev. Alphonse M. Schwitalla, S. J., St. Louis; vice-president, Rev. Maurice F. Griffin, Cleveland; secretary and treasurer, Sister M. Irene, St. Mary's Hospital, St. Louis; executive board, Sister M. Allaire, Grey Nunnery, Montreal; Sister Helen Jarrell, St. Bernard's Hospital, Chicago; Sister Marie Immaculate Conception, St. Mary's Hospital, Green Bay, Wis.; Sister M. Rose, Mercy Hospital, Pittsburgh; Mother M. William, Convent of the Incarnate Word, San Antonio; Mother M. Francis, St. Joseph's Hospital, Orange, Cal.

The opening day was given over in the morning to the formal proceedings connected with the greetings from the college, the president's address and various committee reports; while in the afternoon there were group sessions on professional standards, the medical side of administration, including a discussion of nomenclature by E. H. Lewinski Corwin, and some discussion of various aspects of nursing education.

Wednesday morning's general session was devoted to the topic, "The Spirit of the Hospital," with Father Jos. F. Higgins presiding, and various members of the clergy, including Father Schwitalla and Father Garesche, on the program. Father Schwitalla contributed some especially pleasing comments, in reply to a

question or two from the floor, on the best way of dealing with the hospital chaplain, his advice being to treat him so generously as to make him an enthusiastic ally of the administration.

Wednesday afternoon sessions included one of the most interesting of the meeting, under the direction of Dr. Malcolm T. MacEachern, whose lively round tables have been the feature of many conventions. The general topic was the physical factors in administration, and some excellent papers were read. Father G. Verreault, of Ontario, discussed the subject of cost accounting, pointing out that careful checking of figures often shows opportunities for the economies which are essential under existing conditions. He urged that the cost of charity work, including proper allowance for the nursing services given by Sisters, be clearly shown, for the purpose of securing the allowances made by various governments to hospitals caring for the poor.

John M. Smith, head of Hahnemann Hospital, Philadelphia, commented in this connection that in view of studies showing that actual per patient costs to the hospital for student and graduate nurses are very close together, it is a question whether all hospitals now operating training schools can afford to continue them. Dr. MacEachern agreed, pointing out that it would require fewer graduate nurses than student nurses.

Dietary costs were discussed by Sister M. Alexius Gavin, St. Joseph's Hospital, Philadelphia, a general hospital of 250 beds. She showed the most minute and exact cost figures, analyzed from every point of view, indicating close supervision over all operations. Varied menus are offered, corridor nurses collecting request menu slips each evening for the following day.

She divides the entire dietary service into four sections—the labora-

tory for student nurses, private room trays, metabolic and other special diet trays, and the milk laboratory. She urged special attention to untouched trays, indicating something wrong, and to diabetic trays, which must be watched with reference to insulin treatments. A four-months' study showed 14,352 trays served, at a food cost of 23.3 cents per tray, and an overhead cost per tray of 6.5 cents. Sister Gavin said in answer to a question that she purchases all supplies on the open market as needed, thus securing advantage of immediate choice and not having large supplies on hand which are not needed.

Dr. MacEachern recalled a case he had observed where a hospital had let its garbage contract to a Chinaman for \$200, giving him 28 barrels a day. A recheck on waste cut the garbage to eight barrels a day, making the contract extremely unprofitable. A discussion as to supplying patients with special luxuries, such as lobsters, revealed a general opinion that anything in reason should be supplied, but that lobsters should be gently and firmly refused on the ground of doctor's orders.

Central linen service was discussed by Sister M. Felicite, St. Vincent's Hospital, New York, where the laundry is handled on an exchange basis, and where this system is said to work well, especially in reducing losses.

An interesting paper on a central supply service, by Sister M. Francis Xavier, St. Francis Hospital, Peoria, was read by another Sister. Central supply service, it was pointed out, is not a store-room, but rather a channel through which all supplies must pass on proper requisition. It can be started in any hospital by collecting miscellaneous supplies which have become scattered throughout the institution, with surprisingly few additional purchases to be made. Nothing should be taken out of any store-room except through the central sup-

ply room, where a clerk (a graduate nurse, assisted by a student nurse) is on duty at all times. Special trays, even prepared to meet the whims of individual surgeons, are taken care of adequately, with more routine items. The filing system is the control, as it allocates responsibility for everything and enables check for return to be made on the responsible nurse.

The group adopted a resolution favoring central supply and central linen services, as well as resolutions of hearty thanks to the speakers and to Dr. MacEachern.

Some of the special medical problems of administration were discussed at another Wednesday afternoon meeting, presided over by Dr. Thos. J. Ryan, with Drs. James P. Dean, Eugene R. Whitmore, Y. Yoshida and Herbert C. Fett, and Howard C. Newton, Ph.G., as speakers; while still another section discussed some special aspects of the training school, Father Terence H. Ahearn, presiding. Dr. E. Lee Shrader and Sisters M. Andrew, Mary Florence and M. Mechtilde were the speakers.

What might be called the keynote of the convention, the economic measures necessary to meet present conditions, was struck Thursday morning at the general meeting presided over by Father Griffin, who himself delivered one of the most telling addresses on the subject. Following Mother M. Concordia, who stressed the need for harmony throughout the hospital, with regular meetings to discuss matters, Father Griffin spoke. Remarking that after fifteen years of prosperity, and of looking for new ways to spend money, the hospitals must now learn how to reduce expenses, cutting the coat to the cloth, he said that the long flowing robes of affluence are now out of fashion. A million a day for new construction illustrated the money once available.

There are two ways to meet the situation, Father Griffin said. One is to get more money, and the other is to get along with less. On the former point, he strongly suggested that proper steps be taken to secure from various governmental bodies, local and larger, such allowances as are made to hospitals caring for the indigent sick, instead of letting these go by default. Collection of accounts due should also be made, and proper charges should be made to those able to pay.

A comment not often heard from a hospital executive was the forthright statement by Father Griffin that a hospital has no right to be charitable with the goods of others, and

that the hospital's own bills should be paid, otherwise it is taking the property of the supply houses without charge and disposing of it without responsibility. There is a limit to free work by any hospital, he asserted, this limit being its surplus resources.

As to economies, Father Griffin disclaimed having sufficient internal experience to make recommendations, and hence confined himself to some highly pertinent questions. Why has the cost per patient-day trebled? He declared that a competitive attitude, and the desire to have certain things just because other hospitals have them, have been largely responsible for heavily increased costs, and that many frills must be trimmed off to meet conditions.

Group meetings Thursday afternoon were concerned chiefly with medical and health problems, under the chairmanship of Dr. J. Williams Bransfield, Dr. C. F. Nassau and Rev. Ralph J. Glover, Ph.D.

The concluding session, Friday morning, under the chairmanship of Sister M. Henrietta, had as one of the principal speakers Elizabeth C. Burgess, R. N. (who is not to be confused with Dr. May Burgess), discussing the work of the grading committee. After a fine tribute to the unselfish work of the nursing Sisters, Miss Burgess recounted the progress which has been made in the work of the committee, from its establishment of standards of "lowest permissible quality" to its most recent condemnation of methods of nursing education "which have so successfully filled the ranks of nurses with incompetents." She said that the improved returns on the second grading indicated hard work on the part of many schools since the first grading, and suggested that the stimulus to more accurate cost studies must have been valuable, some hospitals having learned that their training school is an expense instead of an asset.

The function of the training school, she said, is to provide an adequate supply of competent nurses at a reasonable price both to the hospital and to the public; and this is the problem to be solved. Training schools should be set up as independent units, the primary aim being education, with all nursing in the hospital being done by graduates. This does not mean divorce from the hospital, Miss Burgess said, but only that the school should not be bound hand and foot by the needs of the hospital.

Among the necessities of the situation, in the light of the requirements suggested, the speaker mentioned

more interest on the part of the state; payment by students for their education; the provision of better education; the establishment of higher qualifications for the practice of nursing; the cooperation of colleges; all nurses for hire of every grade examined and licensed; better aid in securing employment; and the establishment of a national board of nurse examiners, similar to the existing medical board, to enable qualified nurses to secure a license under which they can practice anywhere.

Commenting on Miss Burgess' address, Father Schwitalla remarked that the idea of separating the school and the hospital is all right, if it does not mean the separation of the hospital's educational function from its welfare function. He suggested the University of Cincinnati as approaching the ideal in its medical school, where Dean Bachmeyer is also head of the hospital; and, as he pointed out, nursing schools now have this advantage in the typical set-up.

Among others contributing to the success of the program were Homer F. Sanger, American Medical Association; John R. Mannix, University Hospitals, Cleveland; the Rev. John W. Barrett, diocesan director of hospitals, Chicago, and Paul H. Fesler, president, American Hospital Association.

Following the election of officers and their response, resolutions were adopted thanking all who had participated in the meeting, indorsing the work of the conference on nomenclature; urging collection of proper payments for charity work; indorsing accounting studies, especially on social service and outpatient work; and indorsing progressive work in nursing education, with emphasis on the idea of education as opposed to that of apprenticeship, and increased affiliation with colleges.

SOUTHERN CALIFORNIA

The Hospital Council of Southern California met at Cottage Hospital, Santa Barbara, June 28, to hear Ellard Slack, superintendent, Samuel Merritt Hospital, Oakland, on "What the Northern California Hospitals Are Doing to Meet the Ever Increasing Demand for Lower Priced Accommodations." Dr. French, Miss Swope, Mrs. Armstrong and Dr. Henry Ullmann, chairman, cancer division, Santa Barbara Cottage Hospital, research department, also spoke.

BABIES ALUMNI

The Babies Alumni of Woman's Hospital, New York, James U. Norris, superintendent, contributed \$2,494.50 to the free work of the hospital in 1931, according to the annual report of the institution. The alumni is composed of babies born in the institution. There were 652 new members enrolled in 1931.

Superintendents Can't Win Rightful Status Without Help

Aid of Trustees and Associations Necessary If Hospital Administration Is to Be on Accepted Professional Plane; Hospital Departments Standardized, With Qualifications of Heads Specified, But No Standards Are Set for Superintendents

By THOMAS F. DAWKINS

Chicago, Ill.

THE editorials in HOSPITAL MANAGEMENT on the question of the necessity and desirability for a recognized professional status for hospital administrators seem opportune though they may accomplish nothing more than direct attention to this matter and evoke the usual discussion and comment from a limited number of superintendents. That they do not and will not receive cognizance by those who should be equally interested with superintendents, hospital governing boards and national associations concerned with hospital administration is to be remarked and wondered at.

That the hospital superintendent should be concerned is readily obvious. That hospital governing boards should be concerned is equally evident. As stewards for their community charged with the responsibility for the proper administration of the institution they should require, and it is their duty to do so, that none but executives of proved ability be employed. If they would require the standards for the chief administrative officer of the hospital that they do for the managing head of their private business, they would be the most ardent and insistent advocates of a professional status for hospital administrators which would ensure that only qualified persons would be in this key position. That the national associations have not long since taken the initiative in this matter is little short of amazing.

Minimum standards for hospital procedure in almost all of its phases have been established. There are standards for staff, for laboratories, for the intern, for nursing, for case records, for dietary service, for social service, and all of these regulations either specify or indicate the qualifications to be possessed by the heads of these services. But nowhere do

Here is the first of two frank and highly interesting articles dealing with the need of a professional status for hospital superintendents, or, at least, recognized qualifications for this executive. This article ends with the suggestion that the American Hospital Association study the progress of associations in other fields which have brought their members to a professional plane. The second article will suggest how this accomplishment may be effected. Comments on this article are invited.

we find any standard specified or required for the superintendent, the official who is charged with directing and superintending all of these standardized and regulated services. On this official devolves the responsibility not only to see that all of the requirements of the above standards are instituted and maintained if the hospital is to merit approval, but also to employ, direct, often teach, and superintend the personnel necessary to conduct these services. In view of this is it not little short of amazing that none of the standardizing and regulating associations require that the person who is to institute, maintain, direct, superintend all of this has professional qualifications, education, training, or proved ability?

The editorial inquiry in HOSPITAL MANAGEMENT under the caption, "When Hospitals Operate Without a Superintendent," "Should associations whose objects are to improve standards of hospital service through more efficient administration recognize hospitals which announce that they will operate without a superin-

tendent?" is most pertinent, but one would wish to add the inquiry, "Should hospitals be approved by these associations if the superintendent does not have the professional qualifications and ability necessary for an understanding and application of their standards and to superintend the hospital?"

It would seem worthy of some comment that notwithstanding all of the discussion, the studies and surveys, the committees, the job analyses, the voluminous reports, and the recognition by associations of the necessity for some standard of qualification for the hospital administrator that would have official recognition and endorsement, that notwithstanding all this, nothing has been done other than to study, deliberate, analyze, report, read and discuss.

It is hardly to be wondered that hospital governing boards assume the attitude they frequently do. In the absence of an established status for hospital administrators, the members of boards are not to be criticized if they do not view the superintendent with the same scrutiny and appraisal that they give to the other professional, and, sometimes to the domestic, personnel.

Boards often find themselves in a serious and perplexing quandary when a vacancy occurs in the superintendency. They are besieged by applications from all quarters, individuals and agencies, from persons whose qualifications range all the way from proved accomplishment to those whose claim is based on nothing more than that they are doctors, graduate nurses, salesmen, bookkeepers, clerks and often friends or proteges of a member of the board or staff, or of a politician. It would be hardly fitting here to mention anything about the "competitive bidding" for the "job," it being beside the point.

There being no recognized professional status or accepted minimum standard of qualification for hospital administrators to guide governing boards, it is most difficult for them to measure applicants and make a proper selection. This difficulty is accentuated because there is no association to which they may go for a reliable list of available superintendents whose education, training, experience and accomplishments have been measured by a uniform standard.

If hospital administrators did have a recognized professional status; if there was an approved list of available superintendents at one of the association headquarters to which boards could have access; if standardizing and approving associations would require that the superintendent be a qualified person whose fitness had been established by such a uniform minimum standard, there would probably be more attention and more respect accorded status of this official and less instances of the appointment of persons whose claims were based on friendship or influence.

Probably no business or enterprise is better managed than hospitals and it is true also that there are few businesses where there is so little general attention given to the qualifications of the executive manager. A stranger would be amazed did he know that notwithstanding the peculiar requirements for hospital administration there is no official recognition of the exclusiveness of the profession.

Although individuals and the public have contributed much to hospitals, the contributors seldom know whether the superintendent of the beneficiary institution knows anything about his job. If the public were advised that the money given to hospitals is not in reality charity, but an investment in community health and should return profits in the way of security from disease and prolongation of life, is it not probable that they would be more interested in the management and insist that none but competent administrators be employed? Annually there is expended about a billion dollars for the maintenance of hospitals, which is entrusted to those of whom the public who provide this money know little or nothing.

Is it not high time that hospital administration emerge from the hit or miss class and set a standard which all aspirants to the profession be required to attain? Hospitals have long since advanced to the place where they require the same degree of expert management as commercial enterprises. How many of us would invest our funds in an industry or

business the management of which had no training or experience, or in which the executives were selected and appointed as are many hospital superintendents?

Attempts have been made to establish schools of hospital administration in universities, Marquette, Temple, New York and Fordham, but they made indifferent progress and were discontinued. This was unfortunate, particularly with reference to Marquette University, which appeared to have a good curriculum and might have accomplished much had it the right support and encouragement. However, that these schools did not go far is not to be wondered at; they did not have support from those who will determine the success of any effort to make a recognized profession of hospital administration, the governing boards of hospitals. It will be necessary to have their interest, support and cooperation before any progress can be made. This can be accomplished only through education and persuasion through the national associations.

The American Medical Association, through its Council on Medical Education, Licensure and Hospitals, commendably safeguards the interests and welfare of the medical profession through regulation of medical education, classification of medical schools and of hospitals for post graduate medical education and training. The nursing profession has a watchful and zealous guardian of its interests in the League of Nursing Education. The American Bar Association performs similar service for the legal profession, while the accountants have the American Institute of Accountants and the National Association of Certified Public Accountants.

Would it not be entirely feasible and fitting that the American Hospital Association study the methods which have been so effectively employed by associations representative of the other professions and, by following their example, perform an equally beneficial service for the hospital administrator by adoption of minimum standards and regulations for entrance to this profession, and the dissemination of information for education of the general public and hospital governing boards which would gain recognition and acceptance of these standards and of this profession?

MR. KIDNER DEAD

Thomas B. Kidner, an international authority on tuberculosis hospital construction, past president and one of the founders of the American Occupational Therapy Association, died at Beechurst, Long

Island, June 14. He was an active member of the American Hospital Association, and his contributions to the literature on hospital operation and construction, particularly tuberculosis institutions, was voluminous and authoritative. He was a leader in the occupational and vocational therapy organizations in this country and abroad.

Mr. Kidner was born in England in 1866. He received his training in architecture and building construction at the Merchants Ventures College in Bristol, England. In 1900 he went to Canada as one of the organizers under the Fund for the Improvement of Technical Education established by the late Sir William C. MacDonald of Montreal. He was appointed vocational secretary of the Canadian Military Hospitals Commission in 1915. In 1918 the Canadian Government loaned him to the United States to advise the American authorities on vocational rehabilitation of disabled veterans.

During the war he was associated with the construction division of the surgeon-general's office as consultant on tuberculosis hospitals and after the war with the U. S. Public Health Service and the Veterans' Bureau. In 1919 he became secretary of the National Tuberculosis Association, where he established an advisory service on the planning of institutions, aiding in the development of curative occupation in sanatoria. In 1926 he resigned to enter private practice as a consultant on the planning of medical institutions.

The most recent accomplishment of Mr. Kidner is the first official directory and registry of occupational therapists.

His wife, Mrs. Edith Kidner, was in England at the time of his death, with her daughter, Mrs. Lillian Kidner Roberts and three granddaughters. Mr. Kidner is also survived by two sons, Arthur and Charles, and by a brother, William Kidner of Calgary, Alberta.

DEDICATE BUILDING

The Springfield Hospital, Springfield, Mass., Dr. Eugene Walker, superintendent, recently had its dedicatory exercises. A program of clinics was given for visiting doctors in the morning. Luncheon was served the doctors by the Springfield Hospital staff, and the program in the afternoon was:

Henry A. Field, president of the board, presiding.

"Trees"—Song by the nurses.

Address—Mayor Dwight Winter.

History of the Springfield Hospital—Dr. Ralph H. Seelye.

Address—Dr. F. A. Washburn, director, Massachusetts General Hospital, Boston.

"Moonlight Sonata"—Song by the nurses.

"Passing of the Key" ceremony.

Prayer—Rt. Rev. Thomas F. Davies.

NORTH CAROLINA OFFICERS

Officers elected by the North Carolina Hospital Association for the coming year are: Dr. R. B. Davis, Greensboro, president; Dr. H. A. Newell, Henderson, first vice-president; Bessie Baker, Duke Hospital, Durham, second vice-president; and E. G. Farmer, Wilson, secretary and treasurer. The association met with the Virginia and South Carolina Hospital Associations in Richmond. The same group of associations will meet at Charleston, S. C., next May. The exact date has not been set, but it will be at the time the magnolia blossoms are in bloom.

Unique Continuous Flow Bath Equipment at Grant Hospital, Chicago

By MARY WATSON, R. N.

Superintendent

and

ERNEST SCHMIDT

Director, Grant Hospital, Chicago



THE Woman's Auxiliary of Grant Hospital recently installed a continuous bath in the institution, which will be used mainly for dermatologic, surgical, gynecologic, neurologic and medical cases.

This bath tub is 86 inches long, 39 inches wide and 25 inches deep. It is constructed as follows:

The inside of the tub is lined with stainless steel; next comes a layer of veneer plywood three-quarters of an inch in thickness; then a layer of cork of the same thickness. This is followed by an air space of three-quarters of an inch; then another layer of cork, veneer, and the whole tub is covered with bakelite.

The water is let in by means of two faucets at the head end of the

tub. The outlet is regulated at the foot end. The regulating valve is so arranged that the tub can never overflow. When the water gets to a certain height it automatically flows out of the tub. By having the intake at one end and the outlet at the opposite end of the tub there is a continuous flow of water through the tub. A mixing valve controls the temperature of the water.

The waste pipe is so constructed that either a small or a large quantity of water can be continuously let out of the tub, which is advantageous when the tub is to be cleaned or an immediate amount of fresh water is desired.

A hammock is provided for the patient. This hammock has an iron

galvanized framework. A wire mesh is stretched over this framework so that the water may come through it readily. The hammock has an adjustable foot and head rest and it may be lowered to the bottom of the tub or held at any desired depth. Two worm gear winches on a line shaft with one-fourth inch cables running over pulleys operate the hammock. Two cables are fastened at each end of the hammock and run at a slight angle to the ceiling so as to prevent sway. These cables are fastened to the hammock with bronze snap hooks and may be taken off easily.

Rubber bumpers on all corners of the hammock prevent scratching. There are two connecting pieces of

(Continued on page 32)

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Does the Hospital Field Want Trained Superintendents?

An interesting question has been asked by a reader who has been following the comments on training of hospital executives in *HOSPITAL MANAGEMENT* and who wants to know if the field really wants trained administrators. In answering the question in the negative the reader points to his own experience of two years of futile application for positions, some of which were given to people without experience, and he adds, as the point of his answer that he has been told that 150 experienced superintendents have been listed as applicants for positions by one of the national associations in the hospital field.

Unfortunately, the experience of this man is not uncommon insofar as his being rejected in favor of a local person without training.

The most interesting part of his statement is that part

which says that there are 150 experienced superintendents who have been listed as seeking employment by one of the national associations. It is assumed that this organization regards the individuals as capable and experienced, and the fact that these people are available to contend for any opening which may present itself at first glance would indicate that there is an adequate number of superintendents. However, among this 150 undoubtedly are a number of people who have positions, but who seek to better themselves, or to move to a hospital where certain vexing local conditions may not be duplicated. Even allowing for these, there would be many experienced people available.

Two comments suggest themselves in connection with this reader's question. The first is that a program of education of hospital boards to the value of an experienced and able superintendent is necessary, and the second is that some authoritative symbol of certificate of competency as a superintendent would be helpful in encouraging boards to select experienced administrators.

The need of an educational program among hospital trustees is a topic of perennial discussion, because unless trustees appreciate the importance of trained administrators they cannot hope to develop the standards of service as rapidly as they should be developed. Little of a tangible nature, however, can be offered to show that an organized campaign of this kind is being carried on, and most of the work is being done by individuals as opportunity presents.

At present there is nothing to establish the standing of a hospital superintendent in regard to his experience and ability. Any department head may be a member of practically any hospital association, and so may be workers in some of the departments of the hospital. In other words, there is no special prestige, in the professional or vocational sense, attached to membership in hospital associations, as membership is constituted at present, and actually, as far as mere membership is concerned, the superintendent of 20 years' experience is on the same footing as the person who joined the association yesterday. Membership in some form is offered practically every type of hospital employee, every type of voluntary hospital worker, and practically to any one serving the hospital field in any capacity. So a prospective applicant for a hospital superintendency who says that he is a member of an association only finds himself on the same footing in this respect as any other applicant. And the persons selecting the superintendent find in this membership nothing to give them a clue to any applicant's ability.

But to get back to the reader's question, the hospital field wants trained people because only through such people can hospitals be operated as they should be. Demands for these trained people must be developed at every opportunity, and in the meantime for those in subordinate positions in institutions who desire to progress, some practical means of training ought to be provided.

Why Not an A. H. A. Section For Hospital Auxiliaries?

Some years ago a paper was read at the American Hospital Association on the possibilities of a hospital auxiliary that created a great deal of comment and undoubtedly directly profited many hospitals through the greater zeal and activity that it stimulated in their auxiliaries. The paper gave in detail the activities of one

auxiliary, which has contributed materially to the development of a great hospital.

Last year at Toronto one section was given over in greater part to a discussion of hospital auxiliaries, and at that time the suggestion was advanced that it might be well for the American Hospital Association to encourage attendance of members of auxiliaries and similar groups at the association conventions.

Now comes the suggestion, or rather the question, "Why not a section for hospital auxiliaries at the A. H. A. conventions?"

It would be interesting to poll the membership of the American Hospital Association on this question today and compare the results with a poll that might have been taken seven or eight years ago. At that time while there were some superintendents strongly in favor of encouraging auxiliaries there were others just as strongly opposed to giving them recognition, and in some matters the latter group had its way.

As Mrs. Rhynas points out in her suggestion that a section on auxiliaries would be valuable, some small hospitals could not exist without an auxiliary. This is especially true during the present trying times, but if one were to take the time to study the accomplishments of hospital auxiliaries and aids during the years, it would be found that these accomplishments were monumental.

Some opposition has developed toward the recognition of auxiliaries by superintendents who frankly say that such groups are meddlesome and troublesome. Usually such conditions date back over a considerable period, and they are due to defects in the organization and set-up of the hospital which should be immediately corrected. It always should be remembered that there is only one group legally responsible for the work of the hospital, and that is the board of trustees, by whatever name it may be known. This board, with its responsibilities in the eyes of the courts, certainly ought to insist on deciding all policies, no matter where they originate, and in like manner, no group without legal responsibilities for the management of the hospital ought to attempt to interfere in any activity without first obtaining permission and authority from the board or its agent, the superintendent.

But the helpful and interested hospital auxiliary has for its slogan, according to Mrs. Rhynas:

"We do not want to run hospitals. We want to make it easier for hospital boards and superintendents to do so."

With such a slogan guiding them, hospital auxiliaries could profit greatly by exchanging ideas and suggestions, and certainly the logical place for this exchange is in the American Hospital Association.

When Is a Patient Not a Patient?

The American Hospital Association recommends that hospitals count births as admissions, and babies as patients. Another national association in close contact with every reputable hospital in the field asks that hospitals separate births when figuring average daily census and also when compiling the number of patients admitted.

This situation makes all the more difficult the task of interpreting questionnaires, because some seekers of information may have one method of figuring patient census in kind, and others may be thinking of the second way of counting admissions when they frame a questionnaire. And usually none of the seekers specifies how he or she wants the census or admissions to be figured.

Another comment in this connection is that a number of hospitals count children and adults as patients and do not count babies.

The lack of uniformity in this matter recalls the "good old days," as reported in early A. H. A. transactions when some hospitals simply ignored from the statistical viewpoint any patients who died shortly after admission. These patients were not counted in the patient total, nor in the number of deaths. In other words, a patient who died a few hours after admission simply was not a patient.

While the difference in counting patients, referred to above, is not, perhaps, an important one, yet it is further evidence of the need of uniformity in definitions, a need occasionally recalled to the field by HOSPITAL MANAGEMENT.

The compilation of hospital statistics by the questionnaire method, however, is the most reliable available and also the method which insures a greater amount of information in the quickest and most economical way.

Let's Separate Details From Principles of Administration

A person who has had an opportunity to study a great deal of the literature dealing with hospital administration recently commented that in his opinion practically all of the writers failed to set forth the principles of the subject with sufficient clarity and that invariably details of departmental operation were dragged in. For instance, in a discussion of nursing organization a writer may veer off to a list of supplies for a tray, or while discussing principles of management of another department he may produce a formula for a cleaning compound.

This tendency to drift into details is noticeable at nearly every convention when speakers, with subjects whose titles suggest a discussion of principles, will describe at some length some process or some method of making a piece of equipment.

Those who have had occasion to learn in an intimate way of the troubles of administrative departments of many hospitals find that in many instances these difficulties are traceable to a failure to set forth and abide by generally accepted principles of organization or operation. Since this is so, it would seem that a great need of the field is a clearer presentation of fundamental principles.

One reason why there is a tendency to present details is that the average superintendent is daily confronted with details. The number of hospitals whose superintendents have assistants to relieve them of these details is comparatively small, and in most institutions the superintendent simply must be familiar with details of cleaning, maintenance, and many other things, because he or she hasn't an assistant, and furthermore, the subordinate personnel in many hospitals is not inclined to be aggressive in thinking out solutions of problems arising in their daily routine. So, a better way to count linen, or a new method of requisitioning supplies, to many superintendents represents something that is intensely interesting and practical.

But these same superintendents, for the most part, because they are so concerned with details, sometimes have no opportunity to look into the accepted principles of administration to see if their own institutions are set up according to these principles. And the principles of hospital organization and administration and their importance will not be as well stressed when principles are mixed with details as they will when the principles are set forth by themselves in a clear cut and simple way.

COMMUNITY RELATIONS

Suggested Articles for Your Local Newspapers

Potatoes Not So Cheap In 1917, Hospital Recalls

(For week of July 18)

"Potatoes are cheaper, tomatoes are cheaper," sings the 1932 bard, but this song could not have been written 15 years ago, according to (name), superintendent of Hospital, for in 1917 one of the pressing worries of hospital executives was the discovery of an economical substitute for the costly potato. This interesting information was gleaned from the current issue of "Hospital Management," a publication devoted to hospital administration, which, according to (name), reports that 15 years ago at one important convention of hospital superintendents considerable discussion was given to a paper on substitutes for potatoes. Macaroni was one substitute that received favorable mention because of its relative cheapness.

From the standpoint of low cost of potatoes and foodstuffs, the superintendent adds, the words of the song certainly are true this year. But the hospital requires such an unusually high percentage of personal service in serving the sick that the cost of provisions alone represents a minor portion of hospital expense. In many hospitals, as many as six to twelve persons work from one to several hours doing things for the benefit of one patient. If a business man or a housewife had to employ so many specially trained people even for only a few hours a week, the expense would be considerable, and thus the very fact that illness requires such a higher percentage of highly skilled personal service is one reason why the expense of maintaining a hospital is great, and is further increased, relatively, when, as at present, the number of patients is smaller than usual.

Hospital Expense Up As Patients Decrease

(For week of July 25)

"With widespread price cutting taking place," said (name), superintendent of Hospital, yesterday," many may wonder why hospitals have not reduced rates.

Copy these articles, making one copy for each local and nearby newspaper, club, church or other publication. Fill in name of individual, of hospital, and facts and figures indicated. Send copies at time suggested to every editor. Many hospitals are regularly using these articles for helpful publicity throughout area from which patients come. Please send clippings of articles published in the local press to "Hospital Management."

Relatively few hospitals have announced reductions, for the simple reason that hospital expenses have tended to increase because of fewer patients. A hospital must be prepared to give service in its laboratory, operating room, X-ray, and other places at a moment's notice in case of accident or sudden illness. Trained people must be available at all times. The cost of maintaining these necessary services, when spread over a large number of patients, is less per patient than when it is spread over a smaller number. Trained hospital workers cannot be hired and discharged as the number of patients varies. For instance, a laboratory technician is needed whether there are 20 patients in the hospital or only 10. The same applies to other departments, and so it can be seen that many hospital workers are essential for the proper care of



the sick even when only a handful of patients may be in the hospital.

"It also ought to be more generally understood that this specialized personal service is what is most important in carrying out the orders of the physician. While hospitals use a great deal of equipment of a labor-saving and scientific nature, all of this would be practically valueless to the patient unless trained personnel were employed to operate the equipment and to carry out the orders of the doctor in regard to details of treatment."

Unnecessary Hospital Burden to Community

(For week of August 1)

Interesting comments about hospitals which directly affect every resident of the community yesterday were expressed by (name), the superintendent of Hospital. They were suggested by recent dispatches telling how a wealthy man who died left a sum of money to establish a new hospital in a large city.

"It so happens," explained (name), "that this particular city has more hospital beds than it needs, and furthermore, the sum left would not construct the building of the size the man wanted as a memorial to his family. It has been said that 85 per cent of a hospital building is specialized engineering, dealing with X-ray and electro-medical apparatus, sterilizers and similar complicated equipment. This suggests why the cost of a hospital building, on the basis of the number of beds, is relatively high, and the smaller the institution, the proportionately higher cost per bed, because even a small hospital must have X-ray, laboratory, operating rooms, and other units.

"But the most important thought about this bequest of which we are speaking is this: If the will is carried out, a small hospital will be added to a district where there already are more than enough hospitals. Patronage will be divided, and as a result, neighboring hospitals will have fewer patients and a rela-

tively higher cost per patient. For most of the hospitals the income will not equal the expense.

"And that brings up a big point: When the community type hospital has a loss, this loss is borne by the public, unless the hospital closes and sells out. If a man starts a grocery or retail shop, private funds are employed and, in the event of failure, private funds are lost. But once a community-type hospital is opened, contributions and donations from the public are needed, because so many patients are unable to pay for their care. The continuation of such a hospital depends on continued support, not only in patronage, but in gifts for free and part-free service.

"Every hospital expects to do some free or part-free service, but this, of course, can best be done where there is adequate support from the community and, certainly, when support is divided with an unnecessary hospital, it is not as adequate as it might be."

Figures Show Hospitals Served 14,000,000 in 1931

(For week of August 8)

The hospital system of the United States, of which Hospital, of course, is a part, performed a stupendous task in 1931, according to the annual compilation of hospital statistics by the American Medical Association. The hospitals cared for approximately 7,200,000 patients in their beds, and nearly 7,000,000 others who were sick or injured, but who did not require bed care.

. Hospital did its part of this great task by caring for men, women and children during 1931, in its beds. (If hospital has outpatient department, add: It also cared for men, women and children who came to the outpatient department for treatment or advice of conditions not requiring bed care.)

A total of patient days' of service was required to serve the patients of the local hospital, which means that every patient admitted stayed for an average of days.

To serve these patients, the hospital has to maintain 24-hour service in all departments, for one never knows when an accident or sudden illness will strike that will require the use of expert personnel and the special equipment of the hospital.

\$3,295,000 Given to Hospitals

According to information compiled by HOSPITAL MANAGEMENT from various sources a total of \$3,295,700 was donated or bequeathed to hospitals in the month ending June 30. This is by no means a complete list of hospital bequests, and, in fact, represents gifts of only 39 individuals, some of whom, however, gave to more than one institution.

A summary of the gifts reported shows that seven were donations of \$100,000 or more, 25 gifts of from \$5,000 to \$88,000 each, and seven bequests of \$4,000 or less.

\$1,000,000 Credit for Hospitals

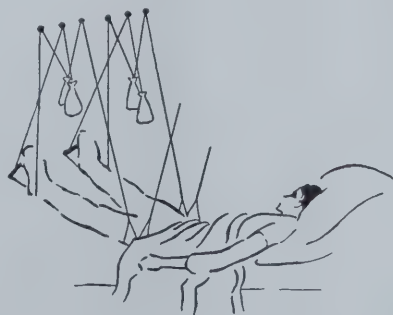
A most unusual announcement and one that will be most welcome to those interested in the continued development and progress of hospitals is made by the Marvin-Neitzel Corporation, Troy, N. Y., largest manufacturers of hospital garments and nurses' apparel, which offers \$1,000,000 credit to the hospitals of the United States.

Full details of the plan have been sent to the hospitals to which this offer is made, and hospitals eligible are urged not to seek this credit unless actually needed, as this cooperation will make possible the extension of credit to institutions which really are in need of this service.

The company frankly says that its success depends on the prosperity of hospitals and its feat of placing \$1,000,000 to the credit of the disposal of hospitals is offered as evidence of the confidence the company has in the nation and its hospitals.

The announcement further points out that the Marvin-Neitzel Corporation has won its way through five of the worst periods of depression in the history of the country.

As an indication of how the field has received the announcement, the



following comments were reported:

"The idea is very fine. We shall pay as soon as we can, but it will help us to have a little time."

"We consider this credit fund a most charitable undertaking and believe a very much forgotten enterprise—hospital work—will be unspeakably benefited."

"Wonderful! There is nothing we need and I doubt if we would care to purchase in this manner, but we do need more than the usual credit."

"While we do not need this Fund, I think it is a wonderful thing."

Minnesota Meeting Well Attended

The Minnesota Hospital Association 1932 meeting was one of the most largely attended hospital conventions of its existence. "Economy" and "hospital management" were discussed freely in the round tables and in the papers.

A joint meeting of the Minnesota State Medical Association and the Minnesota Hospital Association was held at the Saint Paul Auditorium, having as its subject, "Civil Hospitals in the care of Veterans." Paul Fesler, president of the American Hospital Association, presided; E. A. Fitzpatrick, Marquette University, spoke in behalf of the American Hospital Association; Dr. Morris Fishbein for the American Medical Association; E. V. Cliff, member of the national executive committee of the American Legion, in behalf of veterans; and F. R. Bigelow, hospital trustee, on behalf of the taxpayers.

The Minnesota Hospital Association elected the following officers: James McNee, superintendent, St. Luke's Hospital, Duluth, president; J. G. Norby, superintendent, Fairview Hospital, Minneapolis, president-elect; Sister Patricia, superintendent, St. Mary's Hospital, Duluth, first vice president; Dr. Charles Remy, superintendent, General Hospital, Minneapolis, second vice president; A. M. Calvin, executive secretary, Midway and Mounds Park Hospitals, St. Paul, secretary-treasurer; Rev. W. Merzdorf, St. Lucas Hospital, Faribault, and J. J. Drummond, manager, Worrel Hospital, Rochester, trustees for two-year terms; and J. G. Norby, and Miss Lulu M. Aler, superintendent, Maternity Hospital, Minneapolis, trustees for one-year terms.

Mr. Fesler was elected honorary member of the association.

"More Buildings Being Made to Fit Hospital Service"

Structure Erected After a Survey Tends to Minimize Complaints and Reduce Turnover of Personnel as Well as to Cut Operating Costs

By MATTHEW O. FOLEY

WHEN a veteran country practitioner dies, newspapers sometimes relate how in the good old days he forced his faithful nag through snow drifts to an isolated farmhouse where an operation was performed on a patient held to a kitchen table. No hospital would use a kitchen table for a surgical procedure if a specially designed table were available, and it should be recognized more generally that it is easier to operate a hospital in a building designed for that purpose than to make hospital operation fit any building which may be available.

So, as far as "the importance of a survey preliminary to a hospital building program" is concerned, I think such a survey is about as important as anything can be.

There are two parts to a survey: the external, or community phase, and the internal, or operating phase. The external survey is intended to discover what kind and what amount of hospital service the community needs; the internal survey has as its object the interpretation of these findings into a building that will deliver this service satisfactorily and economically.

It is encouraging to note that more buildings are being made to fit hospital service, and the continuation of this trend will do a great deal toward increasing occupants of those vacant beds about which we have heard so much lately by removing some causes of dissatisfaction with hospitals. When you stop to think of it, a great many complaints of patients, probably nearly all of them, are due to an improper set-up of a hospital physical plant. In other words, noise, cold food, delays in service, and numerous other things may represent physical handicaps piled on a willing and competent personnel by an improperly planned building. In such a building the personnel get the blame for noise, for unwarranted de-

"A survey doesn't cost a cent and actually pays for itself many times over in the life of a building."

"A survey will tend to increase patronage of the hospital by removing causes of many common complaints, and it also will tend to minimize turnover of personnel."

"Many complaints of patients regarding noise, delay in service, cold food are due primarily to improper planning, the result of a lack of a survey; actually, the personnel in such a building may deserve high praise for carrying on so well under numerous physical handicaps."

"The superintendent who stays to operate the new building ought to have more of a voice in planning and equipment than he or she sometimes is given."

"The hospital which is constructed after a good survey has smaller turnover of personnel and fewer complaints from patients."

"The time may come when a survey may be obligatory before any new hospital construction."

lay and for many other things, whereas actually they may be exerting much more effort simply because they have longer distances and cramped service units with which to contend, through lack of planning.

A survey not only doesn't cost a cent, but it saves money, time and energy during the life of the building. The only trouble about a survey is that many boards of trustees do not realize how important it is until they have completed a building without a survey.

In this group are a number of people who have assisted in surveys and others who have seen the ill-fated results of ignoring a survey, so it is

hardly necessary to cite many horrible examples.

However, here are just two: Several years ago a man decided to give his home town its first hospital. He hired a local architect, visited a few hospitals, and soon the building was ready. One of the features of which the donor was proudest was the maternity department, an entire floor. About a year after the building was opened a hospital executive asked the superintendent how it was that there was only one patient in the maternity department. The answer was that the townspeople looked askance on a hospital for maternity service, and so the bright and shiny department practically remained unoccupied while babies were born at home. Newcomers to town were the most numerous patients. The point is that if a survey had been made, this characteristic of the community, a conservative, slow-moving people, undoubtedly would have been discovered, and the maternity department planned on a less pretentious scale until local prejudices had been broken down.

Several months ago a county hospital was opened. It was built by a local architect, and the county commissioners didn't think of hiring hospital personnel until it was time to open. When the dietitian was employed, two days before the opening, she found a dining room on the floor above the kitchen, with no convenient means of transportation between the two floors, and no serving space for the dining room.

But even a survey will not guarantee a perfect hospital plant. The visiting expert, who doesn't have to stay and run the hospital and who usually doesn't know much about little local conditions which play a big part in smooth hospital operation, sometimes may be given free rein and the superintendent ignored. This arrangement may result in a plan or a building which the superintendent knows will not function as smoothly as it should. While, of

From a paper read before 1932 Midwest Hospital Association convention.

course, there should be only one final authority in a survey, yet I believe that in many instances more attention should be paid to the suggestions of the superintendent.

In this connection, I also believe that the old saying, "Two heads are better than one," applies in surveys, even if one of the heads is an expert. Not long ago a superintendent proudly led a visitor through a new building which she explained she had planned herself. "What would you change if you were doing it over again?" was asked. "Not a thing!" firmly answered the superintendent. Then the visitor noticed that the doctor's register near the front entrance did not show a single doctor in the house. Upon commenting on this, the visitor was told that the doctors did not use that register at all, since they found the rear entrance more convenient to their parking space. Then the visitor noticed that there were dumbwaiters for trays, also heated food carts. "We wanted central tray service," was the explanation, "but it didn't work out at all, so we're not using the dumbwaiters and are getting good results with food carts." On an upper floor was found a special type of bath tub, piled with linens. "Oh, we never have used this equipment," explained the superintendent. "This room is a little small, anyway, and we are just using it for linen storage."

Although she "wouldn't change a thing" in doing it over again, a half dozen more or less important changes had been made. Perhaps if this superintendent had talked plans over with another person, some of these things might have been arranged differently in the beginning.

I realize that this is just a collection of haphazard remarks, but offer in excuse that a survey before building seems to be so necessary that it is almost impossible to overestimate its importance. However, before concluding, a few features of surveys might be pointed out:

To get best results, a survey must be approached in open-minded fashion. It should seek all pertinent facts, not only those facts which will bolster up a pre-conceived idea as to what the community needs or what the building should be. Sometimes there are conditions preliminary to a survey which destroy much of its usefulness.

Not long ago it was fashionable for larger cities to have community health and hospital surveys. One of these surveys which cost about \$70,000 showed that a certain city had more than enough beds for general use, for children, maternity, and sev-

eral other services. That was about three years ago. A recent comparison of bed capacities in that city showed at least 12 hospitals which had expanded since the survey, principally in the services mentioned. The answer is that those hospitals which wanted to expand said that the findings of the \$70,000 survey did not apply to their part of the town, and the other hospitals felt that they had been ignored in the

survey and that the survey did not represent the situation fairly.

It is significant that at a number of recent hospital conventions there were serious discussions of the importance and necessity of surveys preliminary to new hospital construction and several suggestions have been made through associations that a very careful survey be made before new hospital construction is attempted.

Choice of Surveyor as Important As Survey

By H. C. SMITH

Business Manager, University Hospital, Oklahoma City, Okla.

I WOULD like again to read the first sentence of Mr. Foley's paper "When a veteran country practitioner dies, newspapers sometime relate how in the good old days he forced his faithful nag through snow drifts to an isolated farm house where an operation was performed on a patient held to a kitchen table."

This sentence refers to the type of printed article that has caused a number of institutions to be constructed without a preliminary survey and also the type of sentiment conveyed in this sentence has caused many a campaign to go over the top to build hospitals that were not needed.

Mr. Foley has divided the survey into two divisions, the external and the internal surveys. The external or community surveys should be the first thought entering an individual's mind who is contemplating a hospital building program and with this thought in mind the question naturally arises who shall make the survey. While the survey itself is an important factor it is not more important than the selection of the firm or individual to make the survey, for unless the right firm or party is selected the survey is apt to be worse than no survey at all.

I have outlined six items that should be included in every hospital survey:

First, number and type of beds in the community. This should not only include the total number of beds in the community but should show the number of each type of bed such as surgical, medical, orthopedic and obstetrical, and also the character of the institution in which these beds are located.

Second, location of beds if in a large city. This item would be of importance if the institution contemplated drawing a large percentage of their patients from the immediate locality.

Third, health conditions of the community. Is the community one where the sanitary conditions are accurately super-

vised, is it a congested city or is it a sparsely populated settlement?

Fourth, type of community. Under this item should be considered whether or not the community was a manufacturing center, or a community of people devoted mainly to outdoor activities.

Fifth, growth of community. This is a very important item and I would suggest that the figures in answer to this item not be taken from the local chamber of commerce without verification for if they are there is very little doubt, but what there will be an excess of hospital beds in the community as the local chamber of commerce will invariably be overoptimistic.

Sixth, proximity to other cities. This would be of importance and should receive very close consideration if the proposed construction is to be in a community within reasonable driving distance of a larger city.

The internal survey or the survey to determine the type of institution to be built to best meet the needs of the community as shown in the external survey should be a matter of very close co-operation between the consultant or surveyor and the prospective superintendent of the institution to be constructed, and I would even go further than this in that I believe the major department heads, if the institution is to be large, should also act in an advisory capacity in matters pertaining to their respective departments. This might appear to be an expensive procedure, but the cost of a very few alterations in these departments would more than pay the salary of these department heads during the period of actual construction, to say nothing of the inconvenience and noise caused by their alteration.

In conclusion the present economic condition has caused us all to advance more cautiously, for it has made glaring examples of the institution that was built on sentiment rather than being constructed on sound business principles.

THE HOSPITAL ROUND TABLE

Serve 14,000,000

The eleventh annual presentation of hospital data by the Council on Medical Education and Hospitals of the A. M. A. is a most valuable contribution to the field. For the first time the A. M. A. has asked hospitals to report admission of patients, and the number of births is reported for the second time, the first having been in 1929. The total number of admissions reported was 7,155,976. In addition, there were 708,889 births reported, and the hospitals cared for 6,962,724 out-patients. This means that approximately 14,000,000 patients were served in 1931. The information concerning admissions was obtained from the majority of hospitals, but, of course, is below the actual figure, since some hospitals did not answer. The material in this presentation is of the greatest value as an indication of the size of the field and the activity of different types of hospital service. It is based on questionnaires and on information obtained from correspondents of the A. M. A. There were 6,613 hospitals acceptable for registration by the A. M. A. in 1931, and 490 which were refused registration.

Superintendents' Contracts

At the 1932 Iowa Hospital Association convention an interesting discussion of the question, "Should the superintendent have a contract?" was given. Dr. C. H. Sprague, Polk County Public Hospital, Des Moines, said he had a three year contract with a clause providing for from three to six months' notice of termination by either party. "I think all superintendents should have contracts," said Dr. Sprague. "The field for superintendents is limited, there are no schools for superintendents. The superintendent should have some assurance that he will be protected if he does his work properly. Boards sometimes are whimsical and no superintendent would want to assume responsibility unless assured of support." Miss Margaret M. Stoddard, City Hospital, Newton, said she had a one year contract when she first went to Henry County Hospital, but after three years written contracts were dispensed with. F. P. G. Lattner, Finley Hospital, Dubuque, also said that in his experience the one-year contract developed into a

continuous affair. Several objected to contracts, one saying that the superintendent should be free to leave if he wishes. "Some kind of a contract is very important," said Paul H. Fesler, president, American Hospital Association, "I think this matter should be given careful consideration. A university instructor is appointed from year to year, but after a certain number of years he becomes an associate professor and can only be removed when charges are filed against him. If an injustice is done him all the faculty comes to his rescue. I think the time has come when hospital superintendents should think about an association of this kind. The superintendent should be protected in the same way he would protect a patient. I think that if a board has confidence enough to employ a man it should trust him for a certain length of time. We should think about some kind of an organization where we know if a person is mistreated we could all step in and help him." "The best superintendents recognize their responsibilities," said Dr. M. T. MacEachern, American College of Surgeons, "and from that standpoint I agree that they should have three to five year contracts. There are too many superintendents out of employment and that is not their own fault. We as hospital people should step in and do something."

50-Bed Hospital Salaries

The city council of a small town recently announced the following reduction in cash salaries of personnel of the 50-bed municipal hospital:

Superintendent, \$125 to \$118.75.
Surgical supervisor, \$100 to \$95.
X-ray technician, \$100 to \$95.
Graduates, \$60 to \$57, \$50 to \$42.50.
Secretary, \$80 to \$76.
Cook, \$90 to \$85.50.
Janitor, \$76.50 to \$72.68.
Maids, \$41 to \$38.95, \$39 to \$37.

Better Reports

One of the results of present conditions undoubtedly will be a definite raising of the standards of hospital reports, from the typographical standpoint, judging by some of the volumes received recently. Perhaps the desire of the printer for the job has stimulated him to give greater cooperation and more practical suggestions for improving the appearance and the effec-

tiveness of the publication, but at any rate those who see many hospital reports say that the 1932 crop is definitely of higher standard than those of previous years.

Leading O. B. Hospitals

According to the A. M. A. figures, here are the hospitals with the greatest volume of obstetrical service in 1931 and in 1929:

1931	
1 Lying In, New York.....	3,608
2 Cook County, Chicago.....	3,536
3 Chicago Lying In.....	2,849
4 Boston Lying In.....	2,763
5 Jewish, Brooklyn	2,500
6 Elizabeth Steel Magee, Pittsburgh	2,363
7 Providence Lying In.....	2,363
8 Bellevue, New York.....	2,349
9 Maternity, Cleveland	2,315
10 Providence, Detroit	2,236
Total	26,882
1929	
1 Lying In, New York.....	3,884
2 Cook County, Chicago.....	3,142
3 Chicago Lying In.....	3,101
4 Providence, Detroit	2,426
5 N. Y. Nursery and Child.....	2,383
6 Jewish, Brooklyn	2,293
7 Bronx Maternity, New York...	2,200
8 Elizabeth Steel Magee, Pittsburgh	2,133
9 Boston Lying In.....	2,052
10 Bellevue, New York.....	2,033
Total	25,647

It is to be noted that Bronx Maternity and New York Nursery and Child's Hospitals were crowded out of the first ten in the 1931 figures by Providence Lying In and Maternity, Cleveland. These and some other changes in the standings in regard to number of births for the two years are due to construction, merging with a center, etc., although most of the decreases in births may be blamed on economic conditions.

Here are the gains or losses in births reported in 1931, compared with 1929, including the two hospitals which ranked among the first ten in 1929:

Lying In, New York, loss 276.
Cook County, gain 394.
Chicago Lying In, loss 252.
Boston Lying In, gain 711.
Jewish, Brooklyn, gain 207.
Elizabeth Steel Magee, gain, 230.
Providence Lying In, gain 418.
Bellevue, gain 316.
Maternity, Cleveland, gain 308.
Providence, Detroit, loss, 190.
New York Nursery and Child's, loss 560.
Bronx Maternity, loss 1,273.
The ten leaders of 1931 reported 1,235 more births than the leaders of 1929.

Big Savings at Little Cost Are Possible in Modernizing

Here Are a Few Practical Suggestions as to Departments or Units Which May Be Made Much More Efficient at Slight Expense

By J. C. MURPHY

D. X. Murphy & Brother, Architects, Louisville, Ky.

IT is neither possible nor desirable to enter into a detailed explanation of the various items involved in the modernization of a hospital building. Not only does each hospital present its own individual problems, but the magnitude of each problem and its relation to other physical conditions naturally affect the solution.

For instance, a noisy hospital may find the source of its trouble in street noises or in noises originating in the hospital itself—from utility and serving rooms or from elevator or other machinery. The cure may be effected in a number of ways, depending upon conditions—by acoustical treatment of patients' rooms, or corridors, or rooms in which the noises originate, or by isolating the machinery from the structure. Yet an examination of the whole building may reveal that such an expenditure would be unwise because of the condition of some vital piece of equipment or major fault in the structure. It might be found that the cost of correction may be too great to justify the expense.

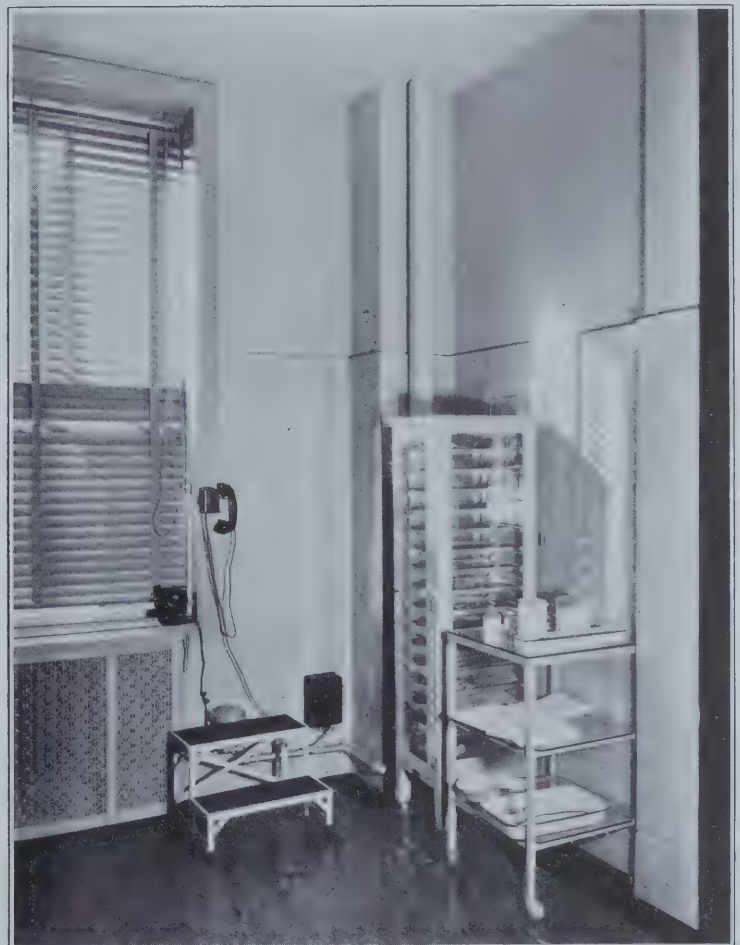
Modernization should be approached with a broad-minded viewpoint and with an eye to the proper balancing of the entire institution. For instance, an improvement of some kind in an operating room would be unwise if the money thus spent could be used to better advantage in replacing an important but obsolete piece of equipment.

An architect who has built hospitals and has remodeled others, and who has studied hospitals thoroughly, is the man who can be relied on to give good advice in a matter of this kind.

The following suggestions for modernization are offered for what they are worth, but in their consideration the condition of the entire hospital building should be constantly kept in mind.

It is believed that the few suggestions offered will indicate possible steps that some hospitals can and should take to improve service without increasing operating expenses or to reduce present expense. Careful

attention is invited to these suggestions, with the first idea of this article again emphasized, that is, that full consideration of the entire building precede any action regarding departmental modernization.



Speaking of modernizing, as some superintendents are who are not in a position to finance new construction, here's how a leading Chicago physician used porcelain enamel tile in a remodeling program in his offices. This new type of tile is said to be stain-proof and such fluids as iodine and mercurochrome are easily wiped off with a damp cloth. Manufacturers claim that this porcelain enamel is easily installed in new or old construction.

15 Years Ago—THIS MONTH—10 Years Ago

From "Hospital Management," July 15, 1917

The Catholic Hospital Association announced that there would be no 1917 meeting on account of the war. The A. H. A. announced its sessions at Cleveland, with special consideration of suggestions of the Council of National Defense.

Several hospitals report increase in salaries to meet rising cost of living.

Toledo, O., Hospital reported 50 per cent increase in all bed rates and 33 per cent increase in operating room fees, to help cover increased cost of operation.

Ohio Hospital Association at its meeting heard dietitians suggest substitutes for the costly potato.

From "Hospital Management," July 15, 1922

Rockefeller Committee on Nursing report recommended 28-month course, and three grades of nurses—bedside, special and teaching, and subsidiary.

Catholic Hospital Association introduced demonstrations at hospitals and a bureau of nursing school problems at its convention in Washington. Convention endorsed National Hospital Day.

Announcement of appointment of Dr. N. W. Faxon as director of Strong Memorial Hospital, Rochester, N. Y. Missouri and Pennsylvania state associations accepted as geographical sections of A. H. A. Trustees also authorized committee on insignia.

KITCHENS

Kitchens are often poorly planned and inconvenient and not provided with proper or adequate kitchen equipment. Much labor can be saved and the comfort of the kitchen force improved by remodeling the kitchen and providing light and ventilation. This may often be done at astonishingly low cost. A shifting of some of the apparatus, or maybe a new unit suitable for the work to be done and the population to be served may be desirable.

DISHWASHING

Many hospitals keep the patients' dishes in the serving rooms on the floors and wash and dry them by hand. It has been found that a small dishwasher in each of these rooms is a great labor saver, and besides, cleans the dishes in a more sanitary manner than hand washing.

LAUNDRY

In many old hospitals the laundry is badly arranged, the laundry machinery of old style and worn out, and the cost of operation excessively high. In one hospital recently completed a new, well arranged laundry equipped with modern laundry machinery cut labor 58 per cent and the volume increased 50 per cent.

WIRING

In nearly all hospitals built a number of years ago the electric wiring is insufficient for the apparatus now used in modern hospitals. Many such hospitals have been examined by actuarial bureaus and a demand made that the wiring be completely overhauled and added to and be made safe. A study of the wiring may remove a fire hazard and reduce insurance.

Patients' rooms should be provided with a receptacle and circuit large enough for the proper operation of a portable X-ray outfit. This recep-

table should not be connected to any circuit to which lights are connected. This sounds big but may be done in old hospitals without great expense.

Each operating and delivery room should be provided with a number of explosion proof receptacles, and all switches in these rooms should also be of the explosion proof type.

The operating rooms should be provided with adequate operating lights. The surgeons will certainly appreciate the installation of such lights.

Receptacles and circuits of proper size should be installed in the corridors for operating vacuum cleaners.

HEATING SYSTEM

A great many heating systems that were installed years ago can be greatly improved in operation, and a very material saving made in cost of fuel by installing new boilers, by resetting the present boilers when they are in good condition, and by installing stokers. Savings also can be effected by adding temperature regulation.

In one hospital recently remodeled, the replacement of an obsolete boiler plant by new boilers equipped with stokers and proper boiler settings for securing better combustion, reduced the coal bill 40 per cent.

In another hospital the addition of a temperature regulating system saved 30 per cent in the fuel bill.

Many heating systems in old hospitals have been improperly installed and the operation is often noisy and inefficient. Efficiency has often been gained in such systems by making corrections in the pipe work at no great expense. This made the systems efficient and noiseless.

UTILITY ROOMS

Many hospitals are not provided with a sufficient number of utility rooms to reduce the travel of the nurses, nor are the rooms provided

with sufficient equipment to make the work easy for the nurses to perform. One hospital completed just a few months ago has a utility room for each twelve or thirteen beds. These utility rooms are situated almost in the center of the nursing area, and in no case is the door of the utility room more than fifty feet from the door of a patient's room. These rooms are equipped with everything the nurses may require and have proved to be labor savers.

Grant Hospital's Unique Bath

(Continued from page 23)

wood underneath the hammock which fold under lengthwise with the hammock when it is submerged. When the hammock is raised either for placing a patient upon it or removing the patient these wooden pieces are turned out and placed on top of the sides of the tub and take the weight of the hammock which makes it rigid. When the hammock is in this position it has the same elevation as most carts, which is of great convenience in handling patients.

A table, which may be tilted in any direction and raised or lowered as desired, is fastened to the side of the tub so that a patient may partake of his meals while in the tub. This table may also be used for reading.

Bath tubs on this order are in very common use at the European medical centers, especially in Vienna, but have not been employed to a great extent in this country. In about 1890, Dr. Hebra, a dermatologist of Vienna, opened a station for continuous baths in the Allgemeines Krankenhaus of his city. In 1917 the original station which Dr. Hebra built was replaced by a new one equipped with 22 continuous baths.

Some Current Hospital Problems

By ARA DAVIS

Superintendent, Scott and White Hospital, Temple, Texas

I AM connected with a private institution and the administrative problems I encounter may differ from those others experience.

It will not be possible within a short time even to enumerate, much less discuss, all of the problems which present themselves. I shall mention only a few, merely to lay the predicate for discussion.

In the face of greatly disturbed economic conditions, I feel sure we will all agree that the greatest problem confronting the hospital administrator today is that of making ends meet financially. It necessitates much more studious attention to collections than has been necessary in the past, but doubtless most hospitals are collecting as much as their patients are able to pay, and so we do not have very much latitude in the matter of increasing our income. The other alternative is to decrease expenses, and this is doubtless of most concern to us.

BUDGET CONTROL

The best way to control hospital expenses lies in the adoption of and adherence to a carefully prepared budget. While we discuss budgets a great deal in our hospital meetings, the average hospital is still trying to get along without going on a budget basis. The depression, however, is offering us perhaps the best opportunity we shall ever have to adjust our business and place our institutions on a strictly business-like basis, since the powers that be behind hospital organizations are now more disposed than ever to lend their full cooperation toward the accomplishment of more economical administration, and those hospital administrators who have not yet put their institutions on a budget basis will doubtless find the time opportune to do so. There is no question but that budget control of expenditures is essential to efficient hospital administration.

SALARIES

In our retrenchment programs most of us have doubtless been confronted with the problem of cutting salaries. This is something I am sure all of us dislike to do, and yet under present conditions salary reductions are not only necessary but are perhaps justified by reduced living costs. The person who receives the same salary

today that he did two years ago ought to be quite a bit better off now than then, and the person who receives from fifteen to twenty-five per cent less now than two years ago is approximately as well off, since the buying power of his money has increased materially, so it does not occur to me that a reasonable salary reduction is out of line. But we ought to be fair and square and thoughtful in our salary reductions, and take care not to lose the confidence and loyalty of our employees, for no institution can survive and prosper that does not have the loyal cooperation and support of those who constitute the personnel of its administrative staff.

PURCHASING, DISTRIBUTING

One of the problems I have had to contend with has been a disposition on the part of department heads to insist upon personally ordering their supplies and keeping these supplies in their departments for use as needed. Of course, I realize this problem has perhaps not been experienced so much by those who operate other types of hospitals, but the management of our institution has been more of a family affair, and department heads have been given more or less of a free rein. However, we have now succeeded in creating a centralized purchasing and distributing system, and this is resulting in quite material savings. One person giving specific and personal attention to buying for an institution can undoubtedly buy more economically, to better advantage, and get better values than can half a dozen department heads buying indiscriminately, and without any particular interest in prices and oftentimes without knowledge of the quality purchased. With some houses now offering inferior products at reduced prices, more skill is required in purchasing than ever before. We have found that by centralizing our purchases we have not only been able to get better prices but better quality of merchandise also, and by centralizing the distribution of supplies have been able to keep closer check on quantities used by the different departments and thereby to effect certain savings in use.

NURSES' SCHOOL

Another problem that most hospitals are facing now is whether to continue operating a nurses' school. This is a problem that we are facing

along with the others, but have not as yet reached a definite decision. Training schools are very expensive to maintain, and it is seriously questionable whether they pay their own way. Many hospital administrators claim they can take care of their nursing requirements more economically and more satisfactorily otherwise. Then it is very evident that we are rapidly accumulating a surplus of graduate nurses. There are thousands of graduate nurses in the country now who can not find work, and so it is questionable whether hospitals are justified in continuing to operate training schools, and continuing to turn out more graduate nurses in the face of an already definite surplus. Every hospital administrator should give this question studied consideration.

RUMORS

I do not know to what extent dealing with malicious and unfounded rumors has become a problem to others, but it seems that few institutions have within these recent months, escaped being attacked by the subtle tongue of the scandal-mongers. I have repeatedly heard false reports to the effect that certain hospitals in different sections of the state have gone bankrupt and have ceased operation. False reports have even come from other states to the effect that some of the largest and strongest medical organizations in the country have been compelled to close their doors. These reports have doubtless been the outgrowth of retrenchment programs. When an institution cuts salaries or reduces force, there is always someone around ready to speculate that it is in serious financial difficulty, and someone else is ready to enlarge on the speculation until finally the report becomes current that the institution is bankrupt and out of business. We have had this situation to deal with, and I can name a number of other hospitals about which similar false gossip has been circulated, to their very great detriment and injury. If anyone can suggest a satisfactory way to deal with rumors of this character, I am sure the suggestion will be gratefully received.

CHARITY WORK

The question of how far we can or should undertake to go in the care of non-pay or charity cases is another problem that must be faced, especially by operators of private hospitals with

From a paper read before 1932 Texas Hospital Association convention.

no special fund for charity patients. I suppose every hospital could, during these trying times, keep all of its beds filled with non-pay patients, since there are more people out of employment than ever before, and more compelled to seek charity. And while every institution must, of necessity, adopt policies along this line for its own protection and survival, we must, nevertheless, do our share of charity, and not seek to shirk the responsibility that is rightfully ours.

ADVERTISING

With most of us the question of how far we can go and how far we should go in the matter of advertising is an acute problem. There is one medium of advertising, however, that is not involved in ethical considerations, nor restricted by economic conditions, and that is the satisfied patron. After more than twenty years' service in the hospital field, I am convinced that no other type of advertising can bring results comparable to the expressed good will of satisfied patrons, and I want to commend this medium of advertising to you. In these days of financial distress when we are curtailed in publicity programs otherwise, we may still have recourse to this most productive and lucrative of all forms of hospital advertising, and if this period of economic stress brings us to a fuller appreciation of the good will and friendship of our patrons and causes us to intensify our efforts to send each one forth as a booster for our institution we may find that the depression has been of real service to us.

SERVICE TO PATIENTS

In closing, let me add a word about service to patients. While struggling against adverse financial conditions, and seeking everywhere for opportunities to cut expenses, we are apt to be tempted to apply cuts that adversely affect service to our patients, and when we do this we are doing something that is exceedingly questionable if not indeed unwise and unwarranted. We ought not ever to lose sight of the fact that service to the patient is the chief function of every hospital. This is something that must be preserved regardless of all things else, for the hospital that disregards its obligation to the patient forfeits its right to survive. The finest thing about hospital work is the opportunity it gives one to render a splendid service to those in need, and the fact that hospitals generally are looked upon as places where the most generous, thoughtful, and humane service is expected and realized stands to the everlasting credit and glory of the hospital administrator.

Why Not a Hospital Aid Section In the A. H. A.?

By MARGARET RHYNAS

President, Ontario Hospital Aids' Association, Burlington, Ont.

HOSPITAL Aids and Their Relation to Hospitals would seem a timely subject upon which to write a brief article relative to the frequent question, "Should Hospital Aids Have a Section Within the American Hospital Association?"

As president of the Provincial Association of Women's Hospital Aids of Ontario (which comprises 60 affiliated societies, representing several thousand women), I have acquired rather a wide knowledge of the achievements, possibilities and ideals of hospital aids generally, hence I take the liberty of expressing a few concrete facts upon the foregoing subject.

First, may I say that since hospitals opened their doors to serve the sick and suffering, women volunteers have played no small part in assisting the hospital board and superintendent.

This large army of volunteer women have developed within their ranks hospital consciousness and have spread the gospel of hospital-mindedness in the community, which has been very evident and telling. I do not hesitate to say that in some instances small hospitals could not exist if it were not for the Aid.

This sympathetic contact between hospital and community makes for a better understanding of all that pertains to hospital administration, giving the citizenship a comprehensive interpretation of the hospital. This plant of benevolence has grown until its branches are to be found interwoven into almost every hospital, whether large or small, and it is felt by many who have an intimate knowledge of the extent and possible scope of the work that progressive steps should be taken in the matter of linking up with the American Hospital Association, if we would follow close upon the ever-turning wheels of development and added responsibilities.



It is realized that wider knowledge and larger vision can only be gained through a wider field of experience, hence the linking up with the American Hospital Association would afford international interchange of ideas and embrace limitless possibilities for serving to spread the influence of the ideals and accomplishments of Hospital Aids and at the same time gain prestige and strength and knowledge through contact with experts of every branch of hospital activities which are all to be found within this limitless and beneficent body of hospital specialists.

The motto of the Hospital Aid is: "We do not want to run hospitals. We want to make it easier for hospital boards and superintendents to do so."

The Hospital Aid stands not only for co-operation with board and superintendent, but every department within the hospital sphere.

As Hospital Aids also represent a large purchasing power, it would seem feasible to open every avenue of information, thus giving the membership an opportunity of seeing first hand new and improved equipment and becoming conversant with advanced knowledge of hospital needs.

The Hospital Aid gave inestimable assistance in advancing and increasing the celebration of National Hospital Day.

Keen interest is taken for the comfort and welfare of the student nurses, and last but by no means least, influence can be made felt by this large body of women in advancing legislative measures to benefit hospitals.

May I digress to say that over one million dollars has been contributed to hospital needs by the Aids comprising the Ontario Provincial Association, one Aid having given two hundred thousand dollars to the hospital and nurses' home in its lifetime, and at present has nine thousand dollars available to assist in contemplated furnishings. Is there any other body connected with hospital activities contributing this assistance? It surely means something in times like these. It would seem advantageous to all concerned that a Hospital Aid Section be included in the various sections comprising the American Hospital Association.

WHO'S WHO IN HOSPITALS

"MADAME PRESIDENT!" is a term which is frequently heard by Miss Bertha W. Allen, superintendent, Newton Hospital, Newton, Mass., who is president of the New England Hospital Association and of the Hospital Administration Club of Boston, and who has served as president of the Newton Hospital Alumnae, the Massachusetts State League of Nursing Education, and of the State Nurses' Association, among other organizations. Miss Allen has been affiliated with the Newton Hospital continuously, with the exception of six years, since 1903, in various capacities. One year of the period away from the institution was spent in post graduate work at Columbia, and for five years Miss Allen was superintendent of Lowell General Hospital. During her tenure of that office a \$200,000 building was erected and equipped. In 1922 Newton Hospital selected her as superintendent, a position she has held since. Her experience in construction and equipment proved especially valuable in 1928-29 when a \$1,500,000 building program was carried out at Newton. During the period she was president of the state nurses' association, from 1928 to 1931, she directed the reorganization of that body, which had a membership of 5,102 in November, 1931.

Laura E. Logan, for eight years dean of the Cook County Hospital School of Nursing, Chicago, has resigned, effective November 1. Frank R. Shaw, president of the board of the school, resigned at the same time, effective July 1.

Through error, it was reported that Florence Wilson was appointed superintendent of Massie Memorial Hospital, Paris, Ky. Miss Wilson was selected as matron, as Lillian M. Purcell is superintendent of this hospital.

Hospital superintendents who won editorial acclaim in their local or nearby newspapers recently include Cordelia Ranz, superintendent, Audrain County Hospital, Mexico, Mo., whose election as a vice-president of the Missouri Hospital Association was the subject of a congratulatory comment in the Mexico "Intelligence," and Bryce L. Twitty, superintendent, Baylor Hospital, Dallas, Tex., who was highly praised by the Kilgore, Tex., "Daily News," and elected an honorary member of the

Kilgore Lions' Club as a tribute to the hospital's service to a 13-year-old patient from Kilgore.

Annie Hatheway Smith, former superintendent of Rockville, Conn., City Hospital, has returned to that institution as superintendent.

Lola Knowles has succeeded Faye



BERTHA W. ALLEN, R. N.
Superintendent, Newton Hospital,
Newton Lower Falls, Mass.

Davis as superintendent of City Hospital, Altus, Okla.

Verne Pangborn, formerly with Oakdale Sanatorium, now is associated with Robert E. Neff, administrator, University of Iowa Hospitals, Iowa City, as an assistant.

Francis Van Buren has been appointed superintendent of the Children's Hospital, Cincinnati, and also will have charge of the Children's Hospital Research Foundation. Elizabeth Pierce formerly was superintendent of this hospital.

Recent changes among state hospital superintendents include: Dr. Leonard P. Ristine appointed superintendent of Cherokee, Ia., State Hospital; Dr. C. A. Everett appointed superintendent of Natchez, Miss., State Charity Hospital; Dr. G. Lamar Arrington appointed superintendent of Matty Hersee Hospital, Meridian, Miss.; Dr. E. H. Maggard appointed superintendent of Eastern State Hospital, Lexington, Ky.; Dr. W. A. Quinn appointed superintendent of Central State Hospital, Lakeland, Ky.

Mary Graham recently was appointed supervisor of the maternity

department of St. Francis Hospital, Litchfield, Ill.

Marie Robertson, superintendent of Berger Hospital, Circleville, O., since that institution was opened in 1930, recently resigned.

Bessie Sharrar has succeeded Leone MacNamara, resigned, as superintendent of City Hospital, Junction City, Kan.

Charles Lee has resigned as superintendent of Flower Hospital, New York. He is widely known in the field, having been president of the Connecticut association during his long tenure of office as superintendent of Waterbury Hospital, and he has been a regular visitor at A. H. A. meetings.

Carolyn Davis, superintendent, Good Samaritan Hospital, Portland, Ore., and a trustee of the American Hospital Association, was elected vice-president of Zonta International, a society of 3,000 women executives, at its recent convention in St. Louis.

Mary L. Hicks, executive secretary, Louisville Health Council, recently was named acting superintendent of Norton Memorial Infirmary, Louisville, Ky., pending the appointment of a successor to Miss Alice M. Gaggis, resigned.

Adah B. Strayer has resigned as superintendent of Wabash County Hospital, Wabash, Ind.

Lt. Col. Walter L. Simpson has resigned as superintendent of Grace Hospital, New Haven, Conn.

Another recent resignation was that of George F. Sauer as superintendent of Lenox Hill Hospital, New York City. Mr. Sauer had been superintendent of the institution for 15 years.

Dr. W. L. Quennell, superintendent, Highland Park, Mich., General Hospital, recently was guest speaker at the Exchange Club.

Dr. Halpert L. Dunn has been appointed superintendent of University of Minnesota Hospitals, Minneapolis, succeeding Paul H. Fesler, now in charge of Wesley Memorial Hospital, Chicago. Dr. Dunn formerly was in charge of the medical statistical department of the Mayo Clinic, Rochester, Minn., at the same time being associate professor of biometry in the University of Minnesota. Before going to Rochester he was associate professor of biometry and vital statistics in the school of hygiene and public health of Johns Hopkins University.

Good Design, Plus Proper Maintenance, Means Satisfactory Service

Here Are Some Suggestions for Economical Maintenance of Mechanical Plant and for Minimizing Waste of Heat, Power, Water, Fuel, Electricity

By N. D. ADAMS

Superintendent, Franklin Heating Station, Rochester, Minn.

THE quality of service which can be expected from the properly maintained hospital mechanical plant will depend only on how well the system has been designed.

Let us consider some of the requirements:

CONSTANT STEAM PRESSURES

1. At the boiler,—automatic control of combustion and feed water will maintain steady primary pressures and prevent surging which further insures the quality of the steam by preventing carry-over of entrained moisture, and dirt.

2. At the equipment,—constant steam pressures can only be maintained through a correctly designed and carefully installed system. Pipes must pitch in direction of steam flow and be adequately dripped at all low points. Water hammer noises are most disturbing to very sick persons. They also cause an interrupted flow of steam and damage to the equipment. Each piece of equipment should be separately trapped. The common use of check valves on a battery of cooking utensils or sterilizers allows the pressure to build up in the return line when one piece is being used causing a sluggish flow to the remaining pieces.

For cooking equipment, 10 to 15 lb. pressure with temperatures ranging from 212 to 250° is sufficient. Higher pressure will cause too fast boiling in steam tables which are designed to warm and hold temperatures, not to cook. If the steam is controlled by throttling the entrance valves wire, drawing of the gaskets and seats will run up maintenance costs.

For sterilizing pressure of 50 to 60 lbs. with temperatures of 300 to 310° F. are necessary for complete sterilization.

For laundry work saturated steam at 90 to 100 lb. pressure applies best for most requirements. Steam containing super-heat does not condense as readily on the inner surfaces of the

This is the second part of an article on maintenance and operation of hospital mechanical plants. The author is in charge of the mechanical equipment serving the Mayo Clinic and Kahler Corporation properties, and this paper was read before the 1932 meeting of the Minnesota Hospital Association.

presses, and causes further trouble by burning the padding.

HEATING

We cannot consider the hospital room from the viewpoint of heating only. It should be an air conditioned room where the air is fresh, clean, humidified and maintained at a comfortable temperature. There is no excuse today for hand control of room heat. You are spending enough every five years for waste heat to install some form of automatic temperature control. There are now on the market several types of control which can be easily installed in any building (new or old). The patient's welfare demands it. Humidity goes hand in hand with heating. Dr. E. C. Rose now of the Mayo Foundation in his discussion of humidity and its relation to respiratory infections, quotes from E. Huntington, professor of climatics, Yale University, "A study of many thousand postoperative deaths in relation to humidity leads him to believe that if a proper relative humidity were maintained in hospitals, such deaths might be reduced by twenty per cent." There are humidifiers now available which can be readily attached to the radiators, the operation of which maintains a uniform evaporation of water, directly proportionate to the heat emitted by the ra-

diator; thereby maintaining a constant relative humidity.

Where rooms are ventilated by central system, it is quite easy to filter, wash, and humidify the air, but a greater percentage of hospitals are not so equipped. If the rooms in these buildings are held at a comfortable temperature and humidity there will be less cause for opening the windows which allow dust laden air to enter. The old idea that the carbon dioxide content will build up in a closed room and become harmful has long since passed into discard. Sufficient oxygen will pass through the cracks around openings and through porous material to maintain normal percentages. Results obtained at the research laboratory of the American Society of Heating and Ventilating Engineers show conclusively that body comfort is mainly controlled by temperature, humidity and air movement.

WATER

Water supplies should be dependable, clean, clear and free from contamination. The pressures maintained within the building should be constant. Sources of contamination in the piping system should be guarded against. No fixture such as water closets or sterilizers requiring a below-the-water-line connection should be installed without an anti-back syphon fitting.

Hot water temperatures should be constantly maintained by automatic regulators, and circulating pipes. All hot water make up should be softened to prevent scaling in pipes and equipment, this will also prove to be a saving in soap and hands.

ELECTRICITY

Voltages should be maintained as near standard as possible. In order to do this the wire sizes should be over-sized, as more and more electrical appliances are being installed throughout the entire building. Proper fusing of branch circuits will protect the mains and prevent a possible interruption during an emergency.

EFFICIENCIES

If you will maintain the type of continuous service which we have been discussing your efficiencies will be automatically taken care of, yet there are some things we should mention herein.

FUEL

When you purchase coal, oil, or natural gas you are purchasing so many thousands of B.t.u. for one dollar. Which fuel you purchase should not depend on the gross B.t.u. available, but the net amount which can be accounted for in steam.

Net B.t.u. in Steam

Gross B.t.u. in Fuel

Overall efficiency of boiler plant.

This alone does not answer your question, for one fuel may give you a higher overall boiler efficiency and yet cost much more in labor, power, maintenance, and cleaning bills.

One fuel may give you lower costs during your day's peak load, but will fall low in efficiency during the night while operating at low ratings. Results of a single test are not to be relied upon; what you want to know is how much your month's or season's cost amounts to. This can only be answered by making a cost analysis, which is quite simple. Determine the valuation of your steam generating equipment and establish yearly fixed charges such as depreciation, taxes, insurance, and interest. This amount divided by twelve gives you a start. To this amount must be added the items spent for labor, repairs, supplies, and fuel which will give the total chargeable to this account for the month. This amount divided by the quantity of steam produced (in 1,000 lbs) will give you a unit cost.

In a similar manner each branch of the system should be analyzed and its monthly operating cost established.

INSTRUMENTS

To obtain the data required for a cost analysis you will require the necessary integrating instruments. One would not think of driving a car today without a gasoline gauge and speedometer, yet there are many building managers who do not measure the fuel which is delivered to their plant nor do they know how much energy it delivers. The following equipment is the minimum with which you can expect results!

1. Fuel measuring equipment for obtaining amounts fired hourly.
2. Boiler feed water meter.
3. Steam flow meter.
4. CO₂ analyzer and indicator.
5. Thermometer for obtaining steam and stack gas temperatures.
6. Steam flow meter to heating system.
7. Steam flow meter to medium pressure lines.

WATER

1. Meter the city supply or amount pumped from owner's well.
2. Meter line to hot water system.

ELECTRIC

1. Power meter.
2. Light meter.

In large hospitals or institutions consisting of building groups many secondary meters will be needed.

POWER

Power should be generated if it is at all possible so to design your equipment to make use of the exhaust steam. Hospitals are particularly favorable as there is a large hot water demand usually paralleling the electrical. Cooking requires steam at 10 lb. and sterilizers at 40 to 50 lbs. Turbines are now designed to operate at primary pressures of 250 to 300 lbs. with two or three extractions at intermediate pressures for process work. They may be operated during the heating season at 10 lb. back pressure and condensing during the summer time.

Hospitals should have a double source of electricity, insuring light to the operating room. The ideal arrangement is to purchase your power at 2300 volts with primary metering operating your own turbo-generator in synchronism with the power company's only in so far as you can use the exhaust steam. This system of operation is advantageous to both parties as it relieves the power company during their peak load season and gives the hospital:

1. Two sources of power.
2. Cheap power during heating season.
3. Elimination of heavy summer stand-by charge.

You can answer your own individual problem only after having a true analysis of the costs which will balance fixed charges and summer operation against fixed power company's rates.

WATER

Much water is run to the sewer before it has done all the work it is capable of doing.

The waste water from the refrigeration plant condensor should be used as far as possible for hot water supply. Where the drinking water lines are taken off ahead of the house system, condensor waste may be returned to the mains for general domestic use for it has only been raised 10 or 15° in temperature.

It is customary to run the drinking fountain line with a continuous drip to the sewer for maintaining circulation. We have provided circulation by continuing these pipes as supply lines to the overhead tanks supplying automatic flushing for urinals.

Both steam and water may be saved by installing two hot water tanks and piping systems, one for the kitchen, janitor, closets and utility room supply to be operated at 160 to 180°, the second supplying the general domestic needs operated at 110 to 120° F. Much water is wasted by the use of the hand controlled mixing faucet. In the Mayo Clinic tempered water at 110° is the only supply to the room lavatories and it is there regulated by knee controlled valves. This system has cut the hot water use 75 per cent. Further saving in steam may be effected by running the hot water make-up through a coil in the high pressure condensate recovering tank. This is advisable where steam is purchased, but may not be so when operating your own plant as it is advisable to return the condensate to the boilers at as high a temperature as pressures will permit.

Both hot and cold water pipes should be properly insulated. Water closet flush-o-meter valves are a source of much waste if not properly checked for quantity flow. Cooperation is necessary from all employees in order to eliminate dripping faucets. They not only waste a great amount of water, but every leaking faucet will soon need a new gasket. To prevent this trouble close the faucet firmly, if this will not stop the flow call the engineer instead of using force.

ELECTRICAL

Savings in electrical power may be made by checking motor sizes; a motor operating at one-half load is running at a poor power factor. A number of motors operating under the same conditions will cause a false KW demand, on which basis most rate schedules are designed. The power factor of your plant may be raised, first by correctly sizing motors; second by the installation of a capacitor, or third, by installing a synchronous motor designed with a leading power factor on some continuously operated machine. Improving the power factor will give you the further advantages of increased cable and switch capacity which cuts down the copper losses and gives a higher voltage at the point of delivery.

Further decreases in KW demand may be made by study of machine operation. The operating time for some machines may be changed to the off-peak period.

Some hospitals have reduced their electrical light bills nearly twenty-five per cent by careful sizing of lamps; elimination of fixtures with too much diffusion and the cooperation of everyone in turning off of lights.



This photograph does not include all who attended the 1932 banquet of the Midwest Hospital Association, as late comers had to eat in another part of the hotel because of lack of space. It shows, however, that the banquet was unusually well attended, and the banquet program also was out of the ordinary. Miss E. Muriel Anscombe presided.

Western Association Votes for House of Delegates

By W. W. RAWSON

Superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah

THE Western Hospital Association convention at Salt Lake City June 14-16, was a very good success. Some very interesting papers were presented and the discussion was lively. In view of the fact that there was not such a large attendance we got close together and received much inspiration.

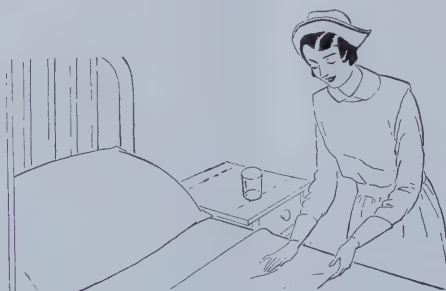
One outstanding feature was the new constitution and by-laws we adopted which in my opinion will have a tendency to make the Western Hospital Association a very strong organization. We adopted by-laws which will permit us to form a house of delegates. Each state will nominate one delegate and then for every \$25 of institutional paid up membership it may elect another delegate. This house of delegates will nominate the officers, thus giving every state representation, and this will have a tendency to give more influence to each state and to the needs of each state. Because of the new constitution and by-laws we re-elected the officers of last year until the next meeting, which will be held at Long Beach next February, at which time the new constitution will go into effect and the states will have nominated their delegates.

Another outstanding thing which we considered was that a resolution was passed that the Western Hospi-

tal Association would co-operate with the nursing associations of the states comprising the Western Hospital Association to raise the standards of nursing. We believe that if we can raise the standards sufficiently that it will cause a number of hospitals now running small training schools on a low standard to close these and employ graduate nurses. Furthermore, the higher standards will increase the efficiency of the hospitals where training schools will be conducted and they will give to the communities a higher class nurse.

Dr. MacEachern and President Paul Fesler were at their best and gave us some very fine suggestions and help and assisted greatly in making our convention a thorough success. Each visitor left the convention feeling that it was one of the best he or she had attended.

"The excellent plans for the meet-



ing were carried out by a committee under the chairmanship of Frank Pingree, Salt Lake City, superintendent, Latter Day Saints Hospitals," commented Dr. MacEachern. "The program committee, under the leadership of W. W. Rawson, Ogden, superintendent, Thomas D. Dee Hospital, provided an excellent program. Most of the discussions centered around the present economic conditions. All the sessions were ably presided over by the president, Dr. B. W. Black, Oakland, Cal., medical director, Highland Hospital.

"The constitution and by-laws adopted marks an important milestone in the history of this organization, providing as it does for a house of delegates. It was thought that much greater interest in the association would be fostered and maintained through a house of delegates consisting of representatives from the 10 states and one province now constituting the association. It was also voted to invite the hospitals in Hawaii to join with the association.

"Through a house of delegates it is proposed to give each of the component units of the organization one member and an additional member for every 25 paid up personal members. In case of institutional membership every \$25 paid by the hospital will allow for an additional delegate. Provision has also been made for various sections of the association and each of these will be entitled to representation in the house of delegates.

"Early affiliation with the American Hospital Association is desired."

The program as published in Hos-

HOSPITAL MANAGEMENT was followed with few changes.

The keynote of the convention was sounded by Dr. MacEachern in an address, "Some Economic Problems Affecting Hospitals Today and Suggestions for Their Solution." The speaker submitted twelve possible suggestions for aid in the solution of these problems. Briefly stated, these are:

1. A national hospital conference.
2. Local hospital conferences.
3. Further building of hospitals inadvisable, generally speaking, at present.
4. Filling vacant beds.
5. Cooperation in use of facilities and services.
6. Local physicians using hospital facilities.
7. Remove political influence from tax-supported institutions.
8. Distribution of charity cases among existing hospitals.
9. Distribution of services in plan of group hospitalization.
10. Government aid to local hospitals.
11. Special taxes to finance hospitals.
12. Extraordinary sources of revenue for hospitals.

The afternoon session Wednesday was devoted to nursing. Much discussion ensued regarding the relative values of student versus graduate nursing services and the costs of each. G. Waite Curtis, hospital consultant, San Francisco, gave a paper on "The advantages of operating hospitals exclusively with graduate nurses" and this was followed by a discussion of nursing standards by Mr. Fesler. A telegram was received from the California Nurses' Association, in session at Santa Ana, urging the Western Hospital Association to take action which would influence the reduction of the schools of nursing. The convention was addressed by Ethel Swope, secretary, state board of nurse examiners of California, who also urged the reduction of the nurses graduating annually, to reduce the over-supply. It was the unanimous opinion of the convention that the most effective method of reducing the number of schools of nursing and the number of graduates, was through the adoption of a set of minimum standards, and it was decided to bring this about at an early date.

During one afternoon session, Mr. Paul Fesler discussed in detail the future policies of the American Hospital Association, indicating the organization and various committee activities. He also described the efforts of the American Hospital Association to have veterans with non-service disabilities treated in non-governmental hospitals.

An interesting feature throughout the convention was the holding of a round table conference at the close of each session by Dr. MacEachern.

Round Tables at Protestant Meet

Five round tables will be conducted in the five sessions of the American Protestant Hospital Association, Statler Hotel, Detroit, September 9-12. Every member will have a part, and visitors are invited to participate in discussions also.

A program of one hour and thirty minutes will be introduced by an address on "Training School Standards," followed by addresses and discussions by the nursing committee on "The Standardization of Nursing Service."

Following the suggestion that the church of the incoming president should be responsible for an unusual Sunday morning service—an innovation to be followed in succeeding years—the authorities of the Detroit Episcopal Cathedral have given their Sunday morning hour to the Protestant Hospital Association convention, and have invited its incoming president, Rev. Thomas A. Hyde, to preach. He will be assisted by some of the clergy of the association representing other denominations. Sunday afternoon a Lutheran rector will discuss what may be expected of healing institutions. The address will be followed by a Forum, led by a Baptist, the theme being "Humanizing the Hospital."

The convention will discuss legislation, hospital procedures in admitting, treating and discharging patients, intern service, handling accident patients, laboratory examinations, and many other topics, including "What Are Hospitals Doing to Make Necessary Economic Adjustments?", records, building surveys,



public relations, "Cardinal Points of the Efficient Hospital," budgets, finances, practical economics, conduct.

The officers and trustees extend a cordial invitation to all hospital representatives to attend the convention which opens Friday afternoon, September 9, and closes Monday noon.

Housekeeper's Duties in Nurses' Home

By Isabel Enright

Housekeeper, Nurses' Home, Hospital for Joint Diseases, New York.

I start my duties as housekeeper in the nurses' home at 7 o'clock in the morning, going through the home to see whether there is a nurse who is ill. If there is, it is reported to the supervisor of nurses. The dietitian also is informed so that trays can be sent up to the sick nurse.

Vacant rooms are reported to the supervisor of nurses and that is where I meet the new nurses and assign them to their rooms, taking care of their baggage and informing them of the rules governing the home.

When I go through the nurses' home in the morning, I make a note of all repairs that have to be done, and submit them to the assistant director on the special forms the hospital provides for that purpose.

The nurses' home consists of 107 rooms, 5 large wash rooms, 7 private bathrooms, and five linen closets. I supervise the cleaning of the home and the work of maids and porters.

Linen is changed twice weekly, and once a week a requisition is sent in for the week's supplies.

I also take care of the nurses' personal linen, sending it to the laundry on Monday morning, and when it is returned to the nurses' home on Thursday, I see to it that it is properly placed in the nurses' rooms.

Inventory is taken twice yearly.

NEW YORK HOUSEKEEPERS

The National Executive Housekeepers' Association's second annual banquet at the Biltmore Hotel, New York, drew nearly 300. President Margaret A. Barnes reviewed the activities of the organization, which has grown from one chapter with 15 members to seven chapters with a total membership of 500. "We have organized to become more proficient in fulfilling our duties. Tonight we have a surprise in announcing the birth of a new chapter in Pittsburgh, with Mrs. Suzanne B. Staley as president," said Miss Barnes.

Mrs. Ellen Beers McGowan, Columbia University, outlined tentative plans for a college course soon to be opened to hotel housekeeping executives.

Mrs. Adele B. Frey, president of the Ohio State and Cleveland chapters, told of the growth of the association in Ohio.

FOODS AND FOOD SERVICE

Looking at Efficiency of Food Service From Three Viewpoints

I. Efficient Ward Service

By EUGENIA MARTIN SHRADER

Chief Dietitian, Barnes Hospital, St. Louis, Mo.

IN this paper I shall discuss briefly such phases of food service as menu planning, purchasing and preparation of food, teaching of student nurses, and last, but surely not the least in importance, the food waste.

It is paramount that there be first of all an intelligent, well trained dietary staff, and a sufficient corps of workers.

One might very aptly say that the food cost, food waste, and possible food satisfaction originates on paper—that is, in the planning of the menus. Even though economy is strongly emphasized, we cannot for an instant consider other than adequate diets in the planning of the menus in an efficient food service. This is where the dietitian must use her skill as a specially trained person in this field, and with one eye on the food market and the other on the welfare of the patient be able to accomplish satisfactory results.

In a large hospital, the dietitian usually does not have the time to do the actual buying, but she should always be in close contact with the purchasing department, and no radical changes in quality or type of foods purchased should be made without her knowledge, otherwise unfortunate results may occur. In the small hospitals where she has the time, it is usually a distinct advantage for her to do the purchasing. Salesmen are steadily increasing their knowledge of their products, and this has been found helpful to the dietitian in purchasing.

Competitive buying is always a wise plan to follow. It stimulates interest and often results in good service and better prices. Very often one firm has had an opportunity to make a quick buy at a very low price, and it acquaints the purchaser with this fact. The dietitian, with some adjusting, should be able to change

her menu in order to take advantage of this offer. This should be encouraged in every way possible, as it not only nets the hospital a saving, but also adds variety to menus, which is a matter of the highest importance.

Even though tempting and well-balanced menus have been planned, and good quality of food has been purchased, if the dietitian is not ever watchful of its preparation, there is great danger of much food waste and added dissatisfaction.

As a rule, hospitals are not able to pay salaries that would attract the best trained cooks. However, with a cooperative and well trained chef, the dietitian should be able to train cooks and cook's helpers to meet her needs. A valuable aid to the dietitian in her ordering and to the chef in the actual preparation of foods is a card file of recipes which have been proved satisfactory by trial. The number of servings that the recipe will make and the price per serving should be on each card. If these are closely adhered to, there should be little worry about variable products. The leftovers will also be reduced.

How can we most efficiently and

Here is an unusual symposium, the theme being "efficiency in food service" and the subject being discussed from three viewpoints—ward service, private service and from the viewpoint of an engineer. This was one of the many enjoyable features of the recent convention of the Midwest Hospital Association in St. Louis.

economically serve food to the ward patient? Central service in its true sense is practically out of the question because of the great cost entailed. The non-insulated cart and steam table service may be used to advantage if the food does not have to be carried a great distance from the kitchen and if the wards are small.

Since the insulated cart has come into use it has been favorably accepted by most dietary departments. It is a very compact manner of sending hot and cold foods to the various wards, and the cart may be transported quite a distance without the food losing any of the original heat and flavor.

The diet nurse on the ward knows at what time to expect the cart so that she can have everything in readiness to start the service. The cart may be rolled directly into the ward. This is a decided advantage to the nurse and attendant as it saves time and steps, and also gives the patient a much more rapid service. The patient may express his desires, so that larger servings of a food liked may be given or a food disliked left off entirely.

Even though we cannot use central service for ward patients, it is well to incorporate some centralizing methods. For instance, how much more efficient and economical it is to have the bread sliced by a machine in the kitchen and sent in to the carts to the wards, allowing so many slices per person, rather than sending up loaves of bread to each ward and trusing that the knife may be sharp and the attendant's cut may be straight. Closed containers may be had which hold one or two-pound loaves. The bread that is not needed for that meal on the ward is returned to the kitchen in a usable form.

Butter is another food in which great waste may occur unless properly handled. Having it cut by a cuber in the kitchen will insure a more uniform pat of butter, and done in this manner, a pound will serve more patients. These and many other devices worked out in the various

dietary departments add to their efficiency and economy of service.

An important factor in the efficient serving of food is the training of the student nurse. She is the medium through whom the food is served to the patient. Her help and sincere cooperation must be obtained. In her practical training in the dietetics laboratory she should be taught to appreciate the value of food economically as well as therapeutically. This training should include actual setting up of trays with diets that are typical of those served in the hospital. Here should be stressed the value of small or medium servings which are more tempting to the patient than large servings and involve less food waste.

As the diet nurse, she can become sufficiently familiar with the patients to learn many of their food likes or dislikes, whether this patient prefers milk to tea, etc. She should be trained to acquaint the visiting ward dietitian with foods that the patients dislike and also with those that are well liked. Thus it behooves the dietitian to train her student nurses carefully and to gain their confidence and cooperation through kindly and sympathetic administration of the ward food service. This may be done by helping them with their food problems, seeing that there is always sufficient food for their patients and that their suggestions are looked into and carried out if advisable.

A feature of food service on the wards which we must always consider is the special diet, for it is there that we find the best examples of certain food deficiencies. Special diets as such should be kept as low in number as possible, as they involve considerable more expense

than the routine hospital diet. It is quite possible by making one or two additions to the general diet to take care of many of these deficiencies. We now know that the addition of liver once or twice daily to the diet of a patient with pernicious anemia is sufficient for his well being.

The diet kitchen should be a part of or located near the main kitchen. This will save duplication of employees and makes the food of the large kitchen available for use on the special diets. Patients on special diets need to be visited frequently in order to keep closely in touch with their likes and dislikes and to note their progress.

One of the true tests of efficiency and economy in the food service other than the daily per capita cost and the satisfaction of the patients, is the weight of the garbage. I can not stress too strongly the importance of a daily check. This can be done by detailing the man who collects the garbage to weigh it and record the weight from each kitchen. If this is not done under the supervision of the dietary department, the dietitian should have easy access to this information, in order that she may act promptly in checking up any unusual food waste. It is interesting to check up the number of pounds per person per day and see whether or not you are keeping within the one pound per person per day in winter and one and one-half pounds in summer, which is considered fairly ideal for the average hospital.

In closing, I would like to emphasize again that an intelligent, well trained dietary staff cooperating with and obtaining cooperation from the various divisions of a hospital service should succeed in having an efficient and an economical food service.

department. The work is definitely divided and assigned, and each worker is held personally responsible for his particular duty. Special emphasis should be placed upon this element of personal responsibility, and upon the fact that only creditable work will be accepted. Then, where the dietitians have the happy faculty of working up among their staff an enthusiasm and personal pride in their work, it ceases to be drudgery, and a situation is arrived at which contributes very effectively to the efficiency of the food service in carrying out its aim, namely, the supplying of good, wholesome, properly prepared, and well-cooked food served in a manner that is both pleasing and inviting.

We might pause a moment to take another glance at the aim as just stated. First, "supplying good, wholesome food"—surely, nothing is too good for our sick! Therefore, only the highest quality food should be given them. There is no advantage or economy in purchasing inferior foodstuffs of any kind. Then, "properly prepared and well-cooked." The greatest possible care and attention should be given to this very important item. Only competent and conscientious persons should be allowed to do this work. For to what advantage would it be to have the best food in the market if it be spoiled in the cooking or preparation? And, lastly, "served in a manner that is both pleasing and inviting." The appearance of the patient's tray may make or mar his meal, for the looks, flavor, color, etc., stimulate his appetite far more than the therapeutic or caloric value of the food. We well know that when food is pleasing to the eye, the nerves of sight and taste are excited and act reflexly on the nerves of the stomach, thereby stimulating the gastric glands. Eating is made more enjoyable, and the result is, in most cases, better digestion, better assimilation, increased strength, and a satisfied patient.

The planning of menus is most important, and sufficient time should be given to it in order to cater to and meet the needs and likes of the sick, and to avoid monotonous meals. Changes should be made every day at every meal. The idea of having fixed menus for each day in each week is entirely to be discouraged. Routine should be carefully avoided—the tray should come to the patient as a surprise. Great diligence must be exercised in ascertaining whether the food is relished by the sick. We interview our patients regarding their meals in order to inform ourselves

2a. Efficient Private Service

By SISTER CLARA

De Paul Hospital, St. Louis, Mo.

ALL are agreed, I am sure, that, until quite recently, the dietary department was too often regarded as the "Cinderella" of the hospital. Today, however, she is taking her place beside her "haughty sisters"—surgery, pharmacy, laboratory, etc.—and equals them in importance in the care of the sick. Hence, no time, labor, or exertion should be spared to bring the standard of the food service up to that of the medical service. For just as the supervisors, technicians and personnel of the

other divisions are fitted by proper courses in theoretical and practical training to carry on their work in a scientific and proficient manner, so should the dietitians in the main kitchen and in the diet laboratory be similarly equipped in their field of dietetics for the discharge of their duties.

Their technical training and practical experience better enable them to give intelligent and efficient direction, and thus bring about a well organized and properly staffed dietary

of their likes and dislikes. We then note them in a record we designate by the homely title of "Likes and Dislikes." Needless to say, it is a great aid when making up the menus.

Central service is a great boon in arriving at the ideal efficiency, which is the aim of progressive dietitians. We find that it works out very successfully at De Paul. The preparation of the meals and trays is concentrated in the main kitchen for the general diets, and in the central diet laboratory for the special diets and formulas. Thus, much unnecessary handling, dishing and reheating of foods is eliminated. The staff become specialists, as it were, in their individual duties, due to their trained experience at the same work under the personal direction and supervision of the dietitians. This makes for proficiency and efficiency, for with each group cooperating and coordinating, good order is maintained throughout the whole process of preparing, cooking, and serving. There are no delays, and the meals are served "on time all the time."

The electrically heated food carts make it possible to take the tray direct to the patient just as it left central service after having been duly

inspected by the dietitian. Our food carts are equipped to carry eight trays. The top shelf is not heated and conveys the cold foods. The hot articles of diet are served from the steam table in hot dishes which are placed immediately on the tray in the heated part of the cart. Thus, the cold foods are served cold, and the hot foods hot, much to the satisfaction of the patient.

The trays are returned to the dishwashing room, where the dishes are scraped and washed, and the food refuse collected and sent to the garbage department. Thus, from the first steps in the preparation of the food even to its final disposal, central service is the efficient servant, proving its value in the economy of time and labor, and in the control of food that it affords.

Those who have given central service an honest and fair trial realize its tremendous advantages, and recommend it as a sure and direct road to real efficiency in food service to the patient. It is a most effective means of enabling the "Cinderella" of a decade or so ago to take her place beside her "haughty sisters" and to hold her head as high when it comes to efficient care of the sick.

are not shown menus at all. The food of every patient on a general diet or a soft diet is exactly the same. This may be satisfactory for ward patients where the food costs and service must be closely watched. Another way is to prepare a menu without choice which is submitted to the patient merely to inform him what is being served. This method may be useful if the dietary staff is large enough so that every menu can be presented by one of the dietitians. In this way minor substitutions can easily be made and the diet adjusted to meet likes and dislikes.

I feel that the choice type of menu gives the greatest satisfaction. The menu must allow a wide enough variety of meats, vegetables, salads and desserts so that the patient may decide which foods he prefers. This does away with special orders and the a la carte service found in many hospitals which brings up the cost. The menus which I find most satisfactory are those on which the foods from which selections are to be made are listed, with a space at the bottom for any special orders which are charged to the patient.

Another fact which we are apt to overlook is that allowing patients to mark their own menus has a sound psychological effect. I think it is important that each patient's menu be on his tray when it is taken into the room so that he, himself, can check his tray, and there can be no question as to the correctness of the food served.

There has been much controversy in the past few years as to how to serve patients properly and, in that I am dealing with private patients, I shall try to adhere to my subject.

The efficiency of the food service will depend a great deal upon the type of service which is used. Many hospitals choose to serve the patients from the floor kitchen, the food being sent up in bulk and served by the floor nurses. Many foods, if put in closed containers, become soggy and unpalatable. Often foods must be reheated and are apt to be scorched or burned. One of two things must then happen. Either more food has to be sent up which adds to dietary cost or the patients are served scorched food and complaints naturally follow.

The food odors and noise which are unavoidable with this type of service are very obnoxious to patients recovering from illnesses and are apt to create a bad impression of the hospital. Furthermore, the food service is not always uniform, for the head nurse, who is

2b. Efficient Private Service

By BETHEL CURRY

Chief Dietitian, Jewish Hospital, St. Louis, Mo.

SERVING the patient, whether he be private, semi-private, or free, requires a great deal of thought. Patients are made up of people of all nationalities and classes, and each nationality has been accustomed to certain types of food. Patients are most pleased when the food of their particular country is served to them. No matter if the meal does not contain the elements of a balanced diet, they are happiest when menus are served that come nearest to that to which they have been accustomed. The dietitian's problem is to plan diets which are not too different from those which they have at home, and yet see that they are well balanced (have adequate calories, minerals, vitamins, etc.) and at the same time have enough variety to make them appetizing and palatable.

Patients more or less expect hotel service. Here, as in a hotel, the guest is always considered first, but few patients realize the difference between a hospital and a hotel budget. Even in times of prosperity the budget of a hospital is necessarily much

lower than that of a hotel, and running expenses are more curtailed. In times of depression it is necessary to give the same type of service as formerly, with the allowance for food and running expenses at a much lower level. May I quote a personal example:

This year, as a check on our dietary department, we had a consultant, who is the manager of all the food service in one of the leading hotels of this city, go over our food service. Much to his surprise, we served 1,097 meals on this particular day with 38 employees, whereas the hotel needed 33 employees to serve 450 meals, besides calling in extra help for special parties.

Since hospital service is so much more complex, in that food has to be carried long distances and yet be kept hot and appetizing, and the number of employees and the budget is so limited, the type of service which is used is very important.

Various policies may be carried out in regard to the serving of patients. In one of these the patients

usually held responsible, may not always be available, and the serving of diets is too often referred to student nurses, who may not have had special training. Moreover, the waste of food with this type of service due to lack of uniformity in servings, ruining of food when reheating, etc., is apt to be great.

Serving food in this way often results in a great deal of confusion between special nurses and division nurses. If the special nurses are allowed to serve first, the food is picked over and patients on general usually take what is left. If the special nurses serve last, the complaint is usually the same.

Aside from the odors, noise and lack of uniformity in tray service, to have the division nurses responsible for serving trays seems to me to be shifting the duties of the dietary department upon the nursing department. The serving of trays takes at least two nurses, more often three or four, away from their patients much longer than would be necessary if the trays were centrally served.

If the dietary department is responsible for the serving of trays on the floors, the number of employees must be increased, for there are usually not enough dietitians available. Either way adds greatly to dietary costs.

In my mind, by far the most economical and most satisfactory way of serving private patients is by central service, though there are many who have criticized it. However, I have found that when those who have attempted to serve diets from a central station have made a failure of it, it was because they did not have the proper equipment. No one should attempt to serve trays centrally without thermos jugs instead of porcelain pots; thick heavy tureens that will hold the heat; hot plates with a hot water bath beneath the regular dinner plate, so that food will remain at the same temperature as at the time it was served; heavy covered vegetable dishes and dish warmers which are near at hand so that dishes are hot before foods are put into them.

A complete central service set-up is necessary. By that I mean a steam table for central service alone, with dish warmers, refrigerators, a sink for filling the hot plates near at hand so that the trays may be served as quickly as possible.

Trays which are centrally served may be delivered in various ways—by dumb waiters, with heated carts and with carts which are not heated. Personally I do not care for the first two types. Any mechanical defect

It is to be noted that one of the persons participating in this symposium favors unheated food carts, upon which the completely set-up trays are carried to the floor serving kitchens, while another speaker uses a heated food cart which has a compartment for cold foods and serves the trays from this cart directly to the patient without using a floor service kitchen. These variations indicate the different combinations of methods which are used in central service.

in the dumb waiter, even for a short period, results in the breakdown of the whole central service system. Many times trays are left on the waiter or are taken to other rooms. There cannot be as close supervision with this type as with cart service.

I do not like heated carts for the reason that they mean duplicate service on the division. It is impossible to put cold foods on the trays if the cart is heated previously. Therefore, all cold foods must be placed in the unheated compartment at the top of

the cart or, if it is a cart without the one unheated shelf, another cart must follow with the cold foods. This results in noise and confusion on the division and there is more chance for mistakes because the set-up of the trays must be completed on the floors.

With unheated carts and proper central service dishes (beverages in thermos jugs, soup in heavy tureens and other hot foods in heavy hot plates) there is no appreciable loss of heat. Occasionally I have a complaint about cold food. Upon investigation I usually find either that the special nurse has gone to lunch without serving her tray or that a patient has decided to eat later, and the tray has stood in the floor pantry until the food has cooled.

Besides the actual improvement in the tray service, the fact that all equipment is kept in one place and that all dishes are washed at one central dishwashing unit makes supervision much easier. It is much simpler to inspect and check dishes and silver, as well as working methods, using the central service method, than if one was dependent upon a ward maid in each kitchen, for it is always more difficult to supervise employees who are scattered through the hospital than those who work in one place.

We have used central service in Jewish Hospital for the past six years and have found it to give the greatest satisfaction.

3. From an Engineering Viewpoint

By G. E. QUICK

O'Meara and Hills, Architects, St. Louis, Mo.

EFFICIENCY in food service is a vital problem in every hospital. On this one point rests a great deal of the economy in operation as well as the service that can be given the patient. Food cost is an important item and in this day of clamoring for lower charges any steps that lower this cost are welcome.

From an engineering point of view, centralization of the control of food service is by far the most efficient method of lowering this cost. Central service may effect a saving as high as 25 per cent, and again it may show no saving whatever. When properly solved by a careful study of plans and requirements it has never failed to produce results.

Since there are many methods or combination of methods for handling central service, each particular lay-

out is a special study. There is no one solution that can be used for all purposes. It is essential that the architect have the full cooperation and advice of the hospital superintendent and his assistants in charge of the particular departments.

The method adopted for central service will have a great deal to do with the actual location of the main kitchen relative to the service lifts or elevators. By using closed and heated carts for tray service it is possible to locate the kitchen at some distance from service lifts. If direct tray service to the floors through service lifts is required, the main kitchen must be close or auxiliary service stations planned.

The number of patients and personnel will of course determine in general the size of the main kitchen

and of the special diet department. This space must then be checked as to the best arrangement of the various items of equipment required. Finally, each item of equipment must be carefully checked and designed for its particular duty. A standard steam table for use in the main kitchen will not prove satisfactory for the special diet department. Special provision must be made for tray storage, dish storage, both hot and cold, salad and dessert service, hot and cold drinks, etc. Time does not permit my going into all the special layouts that constitute an efficient kitchen.

The question of type of materials to be used is very important. Real economy and efficiency can be obtained only by the use of well built equipment. The use of rustless metals in the last ten years has not only improved the appearance of the various units but has also proven a real economy when the life and service of the units are considered.

The relative economy of gas and electricity depends mainly upon the rates that can be obtained from the local-utility companies.

In closing, I would like to leave one impression that may save a great deal of expense in future building. For efficiency in food service, the kitchen must be carefully planned and general type of service settled before the foundation of the new building has been started. The connecting corridors to the kitchen, the service lifts or elevators or conveyors must be definitely established since they affect the construction of the entire building and cannot be shifted at will. Too many hospitals have been rushed to completion before a thorough study of food service has been made. The result has been inefficient service that handicaps the institution every day unless expensive steps are taken to correct the errors.

KENTUCKY NURSE BOARD

Governor Ruby Laffoon of Kentucky recently made the following appointments to the state board of examiners of trained nurses: Mrs. Emma Hunt Krazeise, R. N., director, Children's Bureau, Louisville; Louree Pottinger, R. N., surgical supervisor, Kentucky Baptist Hospital, Louisville; Mrs. Myrtle Applegate, R. N., Louisville; Sophie Steinhauer, R. N., superintendent, Speers Memorial Hospital, Dayton. Mrs. Krazeise is president of the board, and Mrs. Applegate is secretary and inspector of schools.

NOW SHAKER SANITARIUM

Crawford Road Sanitarium, Inc., Cleveland, has changed its name and address and hereafter will be known as Shaker Sanitarium, Inc., the new address being 2475 East Boulevard, Cleveland.

"Can't Pay Dietitian's Salary" Small Hospital Fallacy

By GERTRUDE F. BROWN

Dietitian, St. Luke's Hospital, Richmond, Va.

THERE is one very particular chance for improvement in many of our hospitals which Mrs. Mary de Garmo Bryan has not stressed. She was talking about hospitals which already have dietitians. The majority of our hospitals do not have graduate dietitians. If the medical profession is keeping abreast of the times in the other departments of the hospital, how can it overlook the department of nutrition and leave it to the administration of a housekeeper?

I should like to point out a few advantages of a hospital dietary department under trained, graduate dietitians as compared with a hospital kitchen under another type of worker.

One of the replies most often received when asked why a certain hospital does not have a graduate dietitian in charge of its dietary department is that it is too small to be able to pay the salary of a graduate. This is a fallacy. The savings of a trained dietitian are so much greater than the difference in salary between a trained dietitian and an untrained worker that any director who has looked into the records of hospitals and dietary departments under graduate dietitians will at once agree that the question of salary is not a consideration.

A dietitian as part of her training learns that the keeping of accurate records in her own office enables her to keep her per capita costs at the lowest levels, without sacrificing quality or variety of menus. As she sees where one type of food is higher than it was at a previous, similar period, she immediately investigates and corrects the cause, thereby keeping down the per capita cost.

A trained dietitian knows the value of each food, knows the necessity for a widely varied menu, has learned what the standard is for each dish prepared by her employes, and knows how to tell them to get the correct results in the most economical fashion.

The medical service is alert and knows the advantages or disadvantages

of the newest and accepted methods of treatment by diet therapy. If there is a trained dietitian in charge of the dietary department who can interpret the physicians' dietary prescriptions, he is relieved of the burden of outlining foods for patients. If he orders a third stage Sippy diet, the prescription goes to the dietitian and his concern as to whether the patient will get the proper food is ended. The dietitian goes to the patient and learns his likes and dislikes for foods allowed on that type of diet, explains to the patient why certain restrictions are made, and answers any questions the patient may desire to ask concerning his dietary regime, thereby beginning his education of the procedure he must follow for some time. If a dietitian is not in charge, the physician must outline in detail the foods which the untrained worker may serve and use his valuable time for instructing the patient.

The problem of teaching the student nurses and patients is one that cannot be met by an untrained worker. A nurse must be taught the fundamentals of nutrition; she must understand how properly to nourish a person in health and why, before she can supervise a patient's diet or understand how he is being treated by diet therapy. A person not trained in this subject cannot teach it, and the practice of sending nurses to a teacher of cooking in the public schools does not supplement the lack known to be present in the hospital. Teachers of nutrition in public schools are not familiar with hospitals and their perspective is entirely different from that of a trained hospital dietitian.

Often it is necessary, even in small hospitals, for its patients or those not requiring hospitalization to receive instruction in their dietary habits, or for them to be taught how to calculate their diabetic, obesity, nephritic diets, etc. Physicians know all the principles, they know the diets their patients must have, but not many of them have calculated or weighed diets often enough to know what constitutes ordinary, servable portions in grams. Not many know whether 10 grams of butter or 40 grams could be used with ease in one meal. Much of the physician's

From a discussion of a paper by Mrs. Mary de Garmo Bryan at the Tri-State Conference, Richmond, Va., 1932.

Flash judgment pays a dear price

To guess is to gamble! When it comes to the purchase of major equipment for your hospital you don't wittingly take a chance. But actually you speculate with the hospital's funds when you buy an untried product from an unknown source. It's easy to recognize your money's worth. Examine the experience of the manufacturer. Check his responsibility. Demand reliable guarantees.



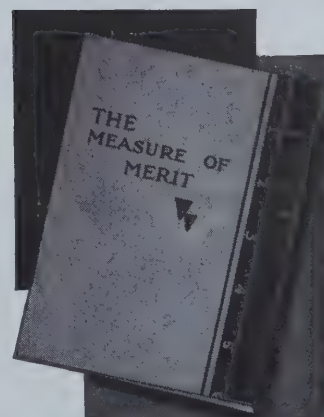
The Ideal Food Conveyor System is well known in the hospital field. It is generally accepted as the meal distribution method that meets most requirements. Sometime a better method may be developed but the chances are that it will be an Ideal development. We've put more time in this branch of hospital management—we've contributed more technical knowledge to it than any other manufacturer. It's no wonder that "Most hospitals use food conveyors—and most food conveyors are Ideals."

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The eight guides to better equipment buying are given in this little book, "The Measure of Merit." Write for it.

time could be saved if he could turn his patients over to the hospital dietitian for instruction.

Therefore, in addition to the points which Mrs. Bryan brought out regarding the improvement of hospital food service may be added our own need for dietary departments under trained dietitians.

These Things Show Dietitian's Value

By Aileen Brown

Director of Dietetics, Hospital Division,
Medical College of Virginia, Richmond.

In connection with Mrs. Bryan's talk and the discussion, I wish to point out that the hospital dietitian is not only valuable from the food administration and educational side, but also as an economic asset as far as use, care and purchasing of equipment are concerned. This phase of a dietitian's responsibility is a big item in the expenditure of the hospital.

The Virginia Dietetic Association has been able to contract only 24 graduate dietitians in the state, 14 of them being in Richmond. We have cities in the State of Virginia with a population as large as 45,000 people without a graduate dietitian. This indicates the large percent of our hospitals in Virginia that do not have their food departments directed by graduate dietitians.

In the hospitals of your states, I wonder how many use silver with a number or monogram showing in what unit each piece belongs, a system for checking weekly the standard silver count, amount on hand, number missing. I wonder how many have the same grade of china with a different pattern for each unit within its department, how many select the china most adapted for the unit it will be used in. Who considers the cost of that china in relation to its durability, the amount to purchase in relation to former breakage, storage space, number of times it must be used daily and the efficient method of handling?

When there are several units in a department, this simplifies the replacement of breakage and the taking of inventories. Vitrified china of medium weight and welded handles cost more when purchased, but give better and longer service. This places responsibility in its proper place and provides an adequate means of checking the china and silver.

The dietitian studies equipment, knows the construction, understands the mechanism and operation of each

piece of her equipment, because of this, she demands the proper care and best use of what she has. This increases the life of her equipment and in return gives better service at less cost. As dietitians go into new fields, equipment is one of her biggest problems. It is necessary to know equipment in order to keep it up.

The dietitian considers linens and keeps a file of the amount on hand,

distribution to the units, and amount laundered daily. She also knows materials and can judge the kind to use for her department.

To be efficient in her work is the dietitian's goal. In order to reach that goal, she must know foods, understand all types of people, be able to organize and build up her department and be ready to cooperate with those she comes in contact with daily.

Evaporated Milk Formulæ Used at Los Angeles General Hospital

By OSCAR REISS, M. D.

Los Angeles General Hospital, Los Angeles, Cal.

ALTHOUGH we have successfully fed evaporated milk formulae to infants on various occasions during the past fifteen years, it was not until last year that we attempted to feed such formulae on a large scale. Our results have been so gratifying that we are tempted to offer our experience as further corroboration.

This work was prompted primarily by the need of an infant food which represented economy and simplicity. At the Los Angeles General Hospital and at an infant home, where our work was done, the intelligence and economic status of the parents of babies is of a low level. Since the preparation of evaporated milk formulae is remarkably simple, and its cost the lowest of any acceptable food, it seemed to us the ideal type of feeding to meet our problem. Further, the addition of sufficient lemon juice to provide adequate antiscorbatic needs was deemed important in that it effected an economy of nursing time by saving an additional feeding of orange juice. This acidification also permitted feeding in concentration if desired.

Two evaporated milk lemon juice formulae were selected for use:

FORMULA No. 1

Evaporated milk	..... 14 oz.	Fat	..... 3.5
Water	..... 16 oz.	Protein	..... 3
Karo	..... 2 oz.	Carbohydrates	..... 10.5
Lemon juice	5 tsp.	Mineral salts	..... .7
pH—5.35			
Calories—26 per ounce			

FORMULA No. 2

Evaporated milk	..... 14 oz.	Fat	..... 3.2
Water	..... 20 oz.	Protein	..... 2.8
Karo	..... 1½ oz.	Carbohydrate	..... 8.3
Lemon juice	5 tsp.	Mineral salts	..... .6
pH—5.61			
Calories—21 per ounce			

These figures represent approximate percentages.

Formula No. 1 was fed to all undernourished infants because of its high concentration. Formula No. 2, with a lesser concentration and with the caloric value of breast milk, was the routine formula for all but the undernourished. In addition, all infants were fed adequate amounts of cod liver oil.

We wished first to determine results of feeding evaporated milk formulae to well babies. Do such formulae result in as good or better dered milk, etc.? Is there a difference in gains and nutritional state than those prepared from fresh cow's milk, powder in the incidence of gastro-intestinal upsets?

For this study, 45 well babies, entering our infant home, and ranging in age from two weeks to five months were placed on evaporated milk formulae and closely observed for a period of six months, with notations as to appetite, stools, gastro-intestinal upsets, gain in weight and nutritional state. These observations were compared with similar records kept of 45 infants who had been fed certified milk formulae the previous year.

The results:

1. There was no difference noted in appetite.

2. The incidence of gastro-intestinal upsets was less frequent in the evaporated milk group.

3. A number of infants fed on evaporated milk Formula No. 1 showed a tendency to vomit. This was quickly corrected by the substitution of Formula No. 2.

4. Weight gain was slightly in favor of those fed on evaporated milk. This is probably explained by the fact that these babies on an average were receiving food of higher caloric value.

5. No evidence of scurvy was noted in either group.

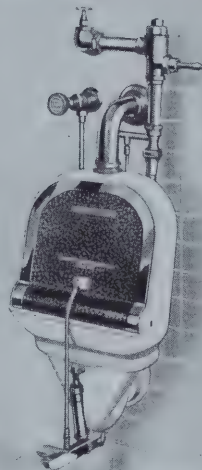
6. The nutritional state as measured by weight, tissue turgor, muscle tone, sense of well-being, developmental progress, and response to environmental stimuli, was excellent in both groups.

From a discussion at 1932 Tri-State Meeting, Richmond.

From an article reprinted from "Archives of Pediatrics."

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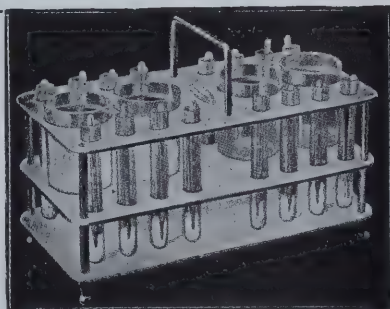
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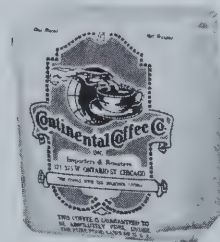
NOT even a sunstroke brought on while playing under a scorching July sun could dampen Nancy's enthusiasm for golf. At least so she told her friends who visited her at the hospital afterward. "No wonder I am recovering so rapidly," she said. "I get the best of attention, including a nice, tall glass of refreshing, delicious iced tea regularly. It certainly brings life and energy back in a hurry."

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7. We effected a saving of 35 per cent in our milk bill.

Our next question: Are these evaporated milk formulae well suited for use as a routine food for practically all infants, entering infant wards in a large general hospital? Are they peculiarly adapted to the feeding of certain types of sick infants?

Accordingly, 240 infants admitted consecutively to our wards at the Los Angeles General Hospital were selected for this observation. The infants alternately fell into two services. Those falling into our service were routinely fed on evaporated milk lemon juice formulae, whereas those falling into the other service were fed various other mixtures, but largely lactic acid milk formulae.

In each group there were a small number of simple feeding cases, a considerable number of undernourished and malnourished infants, and sick infants suffering from gastrointestinal disturbances, upper respiratory infections, pneumonia, phelitis, and the usual other ailments which require hospitalization. The period of stay in the hospital of these infants varied from three to forty-five days. The records of the two groups were critically reviewed and compared with each other:

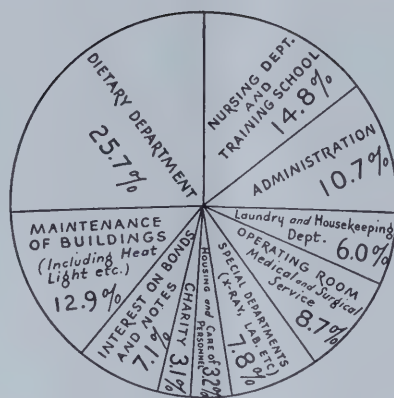
Appetite	
Weight gain.....	
Food tolerance (vomiting).....	
Digestibility (as noted by stools).....	

We were particularly impressed by the spectacular gain in weight of some of our malnourished infants when fed our evaporated milk lemon juice formula No. 1. Gains of eight to eighteen ounces per week were frequent.

Our third question was regarding the feeding of evaporated milk formulae to the new-born as complementary to or substitute for breast feeding. Two hundred fifty new-born infants were observed during their ten-day stay in the hospital nursery. Two hundred thirty-eight were given complementary feedings of Formula No. 2 every four hours in quantity to insure adequate caloric needs. Twelve, who received no breast milk, were offered three ounces every four hours. Formula feeding was begun twenty-four hours after birth.

The results:

1. The food was well taken, with only rare incidence of vomiting.
2. The stools were of good color and consistency, with no odor. Frequent loose stools rarely occurred.



How Grace Hospital, New Haven, Conn., divides its expense dollar. Note relative importance of dietary department expense.

3. There was a uniform gain in weight with little initial weight loss. Two hundred and one left the hospital with better than birth weight, twenty-eight at birth weight, and twenty-one slightly below birth weight.

COMMENT

Like many other medical men, we had long possessed an inherent prejudice against canned milk, but of recent years this prejudice has gradually lessened, I think due particularly to the fact that the quality of milk now used for canning has

Evaporated Milk	Other Formulae—
Lemon Juice	Largely Lactic Acid Milk
Better	Worse
81 gained	76 gained
3 stationary	5 stationary
26 lost	29 lost
8	7
Good	Good

reached a level on a par with milk intended for immediate use.

SUMMARY

1. Our experience as here recorded leads us to believe that lemon juice evaporated milk formulae offer a type of infant food well suited for routine use in feeding of the normal baby during the entire first year of life. They compare favorably with fresh milk formulae as to safety, digestibility, and nutritional value.
2. These formulae are well suited for routine use in feeding of sick infants; and especially suited for the feeding of the under-nourished infants.
3. Lemon juice evaporated milk Formula No. 2 is well taken by the new-born and can be routinely used as complementary to or substitute for breast milk.
4. In institutions and in homes where cost is an important item, a great economy can be effected by their use.



How Some Hospitals Report Costs

The following figures are taken from annual reports of hospitals and are of interest not only for the information, but also as an example of how differently food costs are figured:

"Daily per capita cost of food, including preparation and service, for all patients and employees," 1931—\$0.76; 1930, \$0.89.—New York Post-Graduate Hospital.

"Daily cost per person for raw food, \$0.493; meal cost \$0.164. Cost of preparation, including supervision, \$0.068 per meal. We feed each person for 23 cents per meal."—Grace Hospital, New Haven, Conn.

"Daily average cost per capita for provisions for all persons supported, 1930, 43 cents; 1931, 35 cents."—Muhlenberg Hospital, Plainfield, N. J.

"Kitchen and dining room, private room patients per day, \$0.445; ward patients, \$0.29. Provisions, \$1.607, and \$1.019."—Woman's Hospital, New York.

"Cost of provisions per day for all persons supported, \$0.403, 1931; \$0.476, 1930."—Episcopal Hospital, Philadelphia.

"Exclusive of between meal nourishments and infant feedings, we served 293,846 meals at a raw food cost of 18 cents per meal."—Homeopathic Hospital of Rhode Island, Providence.

SOUTH DAKOTA MEETING

The South Dakota State Hospital Association meeting at Mitchell was very successful, and the entire meeting was reserved for discussion of legislative matters. This was the only topic on which there was an address. This paper was by Dr. H. J. Bartron, Watertown. Definite hospital legislation was deemed necessary and a committee will shortly be appointed to draw up bills and have them presented to the legislative body.

A number of legislative needs were discussed, including protection to the hospital for services rendered following automobile accident, workmen's compensation, a fraud bill similar to the protective bill for hotels, a uniform county, city and state poor act.

Officers elected are:

President, Dr. H. J. Bartron, Watertown; vice-president, Mother Agatha, Sioux Falls; secretary-treasurer, C. W. Carlson, Sioux Falls; trustees, Rev. J. S. Harkness, Mitchell, and Mrs. Dagmar H. Einspahr, Redfield.

Sioux Falls was selected as the convention city for 1933.

The association went on record as being unanimously in favor of Milwaukee as the convention city for the 1933 American Hospital Association meeting.



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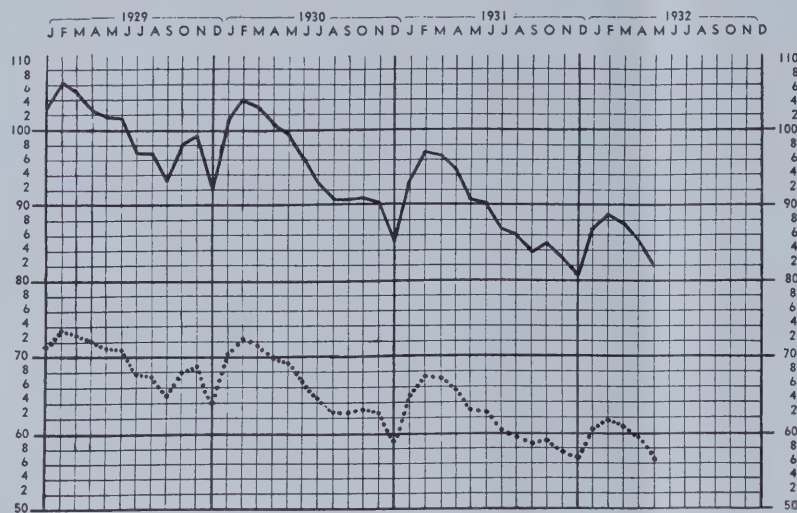
Address

City..... State.....

Hospital

HOW'S BUSINESS?

A composite picture of the percentage of occupancy in 91 general hospitals located in 87 communities in 35 states, corrected for normal growth.



May, 1929.....	2,064,381.77
June, 1929.....	2,034,409.13
July, 1929.....	2,045,112.96
August, 1929.....	2,068,388.63
September, 1929.....	2,050,510.38
October, 1929.....	2,079,042.06
November, 1929.....	2,091,089.31
December, 1929.....	2,127,053.36
January, 1930.....	2,190,909.95
February, 1930.....	2,067,112.17
March, 1930.....	2,120,861.86
April, 1930.....	2,064,328.56
May, 1930.....	2,102,407.49
June, 1930.....	2,027,258.00
July, 1930.....	2,038,042.00
August, 1930.....	1,985,045.00
September, 1930.....	2,079,154.00
October, 1930.....	2,033,163.00
November, 1930.....	2,003,297.00
December, 1930.....	2,031,148.00
January, 1931.....	2,058,681.00
February, 1931.....	1,963,391.00
March, 1931.....	2,026,363.00
April, 1931.....	1,976,430.00
May, 1931.....	1,967,866.00
June, 1931.....	1,932,832.00
July, 1931.....	1,925,156.00
August, 1931.....	1,870,985.00
September, 1931.....	1,890,891.00
October, 1931.....	1,885,424.00
November, 1931.....	1,829,539.00
December, 1931.....	1,889,887.00
January, 1932.....	1,806,279.00
February, 1932.....	1,763,572.00
March, 1932.....	1,762,657.00
April, 1932.....	1,733,486.00
May, 1932.....	1,672,550.00

AVERAGE OCCUPANCY ON 100 PER CENT BASIS

November, 1928.....	69.6
December, 1928.....	66.5
January, 1929.....	71.6
February, 1929.....	73.8
March, 1929.....	73.2
April, 1929.....	72.2
May, 1929.....	71.2
June, 1929.....	71.3
July, 1929.....	67.8
August, 1929.....	67.5
September, 1929.....	65.0
October, 1929.....	68.0
November, 1929.....	68.6
December, 1929.....	64.0
January, 1930.....	70.1
February, 1930.....	72.1
March, 1930.....	71.8
April, 1930.....	70.0
May, 1930.....	69.4
June, 1930.....	66.6
July, 1930.....	64.7
August, 1930.....	62.7
September, 1930.....	62.8
October, 1930.....	62.9
November, 1930.....	62.4
December, 1930.....	59.1
January, 1931.....	64.9
February, 1931.....	67.5
March, 1931.....	67.2
April, 1931.....	65.8
May, 1931.....	63.0
June, 1931.....	62.6
July, 1931.....	60.3
August, 1931.....	59.7
September, 1931.....	58.3
October, 1931.....	59.0
November, 1931.....	57.5
December, 1931.....	56.8
January, 1932.....	60.2
February, 1932.....	61.8
March, 1932.....	61.0
April, 1932.....	59.3
May, 1932.....	56.4

Here Are Figures From Which Occupancy Chart Was Constructed

THE following figures are the basis of the hospital occupancy chart reproduced at the top of this page. These figures were supplied by 91 general hospitals in 87 communities of 35 states, with a basic bed capacity of 16,922.

The first group of figures represents actual number of beds occupied; the second group, receipts from patients; the third, operating expenses of the hospitals for each month since the "How's Business" graphs were begun, and the fourth, occupancy, using 100 per cent as the base.

TOTAL DAILY AVERAGE PATIENT CENSUS

November, 1928.....	11,533
December, 1928.....	11,040
January, 1929.....	11,919
February, 1929.....	12,335
March, 1929.....	12,253
April, 1929.....	12,114
May, 1929.....	11,981
June, 1929.....	12,025
July, 1929.....	11,473
August, 1929.....	11,548
September, 1929.....	11,157
October, 1929.....	11,590
November, 1929.....	11,736
December, 1929.....	10,977
January, 1930.....	12,048
February, 1930.....	12,425
March, 1930.....	12,408
April, 1930.....	12,128
May, 1930.....	12,044
June, 1930.....	11,601
July, 1930.....	11,290
August, 1930.....	10,997
September, 1930.....	11,015
October, 1930.....	11,086
November, 1930.....	11,005
December, 1930.....	10,524
January, 1931.....	11,510
February, 1931.....	11,991
March, 1931.....	11,970
April, 1931.....	11,669
May, 1931.....	11,251
June, 1931.....	11,187
July, 1931.....	10,765
August, 1931.....	10,657
September, 1931.....	10,409

October, 1931.....	10,499
November, 1931.....	10,266
December, 1931.....	10,145
January, 1932.....	10,758
February, 1932.....	11,038
March, 1932.....	10,888
April, 1932.....	10,596
May, 1932.....	10,082

RECEIPTS FROM PATIENTS

November, 1928.....	\$1,678,735.00
December, 1928.....	1,736,302.86
January, 1929.....	1,795,843.79
February, 1929.....	1,776,040.82
March, 1929.....	2,024,823.11
April, 1929.....	1,929,175.70
May, 1929.....	1,920,982.43
June, 1929.....	1,874,173.11
July, 1929.....	1,846,899.32
August, 1929.....	1,867,706.24
September, 1929.....	1,772,230.39
October, 1929.....	1,828,051.39
November, 1929.....	1,786,036.71
December, 1929.....	1,737,404.65
January, 1930.....	1,840,418.05
February, 1930.....	1,799,080.00
March, 1930.....	2,003,309.58
April, 1930.....	1,927,493.30
May, 1930.....	1,921,523.05
June, 1930.....	1,817,813.00
July, 1930.....	1,803,315.00
August, 1930.....	1,719,634.00
September, 1930.....	1,700,314.00
October, 1930.....	1,741,017.00
November, 1930.....	1,640,374.00
December, 1930.....	1,687,813.00
January, 1931.....	1,771,812.00
February, 1931.....	1,720,474.00
March, 1931.....	1,881,003.00
April, 1931.....	1,831,228.00
May, 1931.....	1,815,096.00
June, 1931.....	1,743,189.00
July, 1931.....	1,698,277.00
August, 1931.....	1,598,869.00
September, 1931.....	1,555,436.00
October, 1931.....	1,583,005.00
November, 1931.....	1,497,948.00
December, 1931.....	1,521,552.00
January, 1932.....	1,527,159.00
February, 1932.....	1,468,059.00
March, 1932.....	1,574,446.00
April, 1932.....	1,496,077.00
May, 1932.....	1,453,746.00

OPERATING EXPENDITURES

November, 1928.....	\$1,936,075.00
December, 1928.....	2,064,632.41
January, 1929.....	2,104,552.74
February, 1929.....	2,007,945.24
March, 1929.....	2,099,208.11
April, 1929.....	2,071,386.46

Recent Changes

May Maloney resigned as superintendent of Cook Hospital, Fairmont, W. Va., and on July 1 became field nurse of the state department of welfare of West Virginia. Miss Maloney was in charge of Cook Hospital for five years and for two years has been president of the state nurses' association.

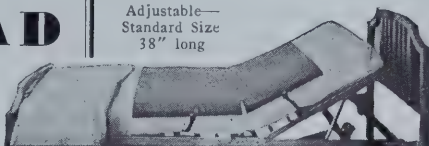
Ruth Singleton, formerly manager of the White Hall, Ill., Hospital, recently resumed charge of that institution.

Helen Branham, formerly superintendent of Brunswick, Ga., City Hospital, is in charge of the new Ware County Hospital, Waycross, Ga.

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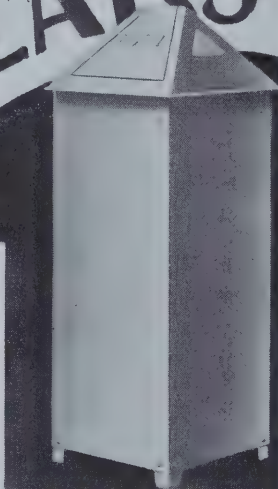
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Now, at last, by requesting nurses for Sedan, the Queen, herself, had put her seal of approval on the work. As "Sisters of Charity" they have served ever since in peace and war . . . For "remarkable bravery in action" they have won the coveted cross of the Legion of Honour. Unnamed crosses without number they have deserved for thousands of deeds no less brave but only less dramatic.

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The Record Department

Qualifications and Duties of a Record Librarian

By Malcolm T. MacEachern, M. D.

Association Director, American College of Surgeons.

This is the first part of a comprehensive paper on the qualifications and responsibilities of a record librarian that every record librarian will want to read. The second part will appear next month. This paper was read at the 1932 meeting of the Midwest Hospital Association.

THE development of the case record as a part of the general evolutionary trend of the standardized hospital has brought into the hospital field a new group of workers known as "Record Librarians." This group, though young in years, is becoming more important and increasingly essential in the hospital plan. Day by day the scope, duties, and relations of the record librarian are being broadened, thereby challenging us to give serious consideration to this group of workers in order to determine how they may best fit into the hospital plan and function to the best advantage. This is the purpose of the discussion which follows.

DEFINITION

At least three grades of personnel must be recognized in the work of record keeping in hospitals. It is common for us to speak of record clerks, record librarians, and medical statisticians. The qualifications, status, and functions of each are quite different and may be clearly defined.

(a) *Record Clerk.*

The record clerk should be capable of assembling the component parts of the record in proper order and filing them according to a standard method. She is not generally expected, however, to be able to carry on a cross-index system or cataloging of diagnoses, complications, and operations. She cannot be charged with the responsibility of making monthly or annual reports or statistical summaries. Generally, she is able to do typing or copy work. This, if necessary, does not require a very highly educated person, but the record clerk should have at least two years of high school training; it is preferable that she be a high school graduate. She is not expected to do more than the physical routine work of the department, which is mainly filing of the records. Most frequently she works under the direction of the record librarian and assists her with the routine of the department.

(b) *Record Librarian.*

The record librarian should have a sound knowledge of stenography so that she may be able to type accurately and take shorthand, including medical dictation, with skill and ease. She should be at least a high school graduate, but preferably should have two years of college work. Her work includes all that outlined above for the record clerk and in addition demands that she be familiar with medical terminology so as intelligently to cross-index diagnoses, complications, and operations according to one of the standard nomenclatures. She

should be capable of compiling monthly and annual statistical reports, as well as know the fundamentals at least of library methods, such as making bibliographies, abstracts and extracts of literature.

(c) *Medical Statistician.*

The medical statistician is the most highly trained of the group dealing with clinical records. Such a person is not only required to be able to accomplish the duties of the record librarian, but in addition must be well fitted to carry on statistical research, comparative studies, and other work of an advanced character in connection with medical statistics and clinical records. The proper background for a medical statistician requires a college education.

The type of institution, the scope of the work, and the progressiveness of the management and the medical staff will determine the type of worker. The very large hospital, the teaching hospital, and others of a highly scientific nature will need all three types of workers, while the smaller institution may require a combination of both record librarian and record clerk. At any rate, in setting up an efficient record department the grade of personnel and the combinations of such must be carefully considered.

QUALIFICATIONS

The determination of the qualifications of hospital personnel generally is an exceedingly important matter. A standard should be set for each type of worker. Following this principle, let us, therefore, briefly outline the more important qualifications of the record librarian.

(1) *Education:*

The record librarian should have at least a high school education, with typing and shorthand proficiency. Possibly a three years' high school with business course and subsequent office experience might be accepted as an equivalent. With two years of college training, in addition, the record librarian could be much better fitted for her work. It needs no argument here to justify the needs for an educational background of a reasonable degree. This is apparent from an analysis of the duties of such a person in the hospital organization.

(2) *Good appearance and pleasant personality:*

Both these qualifications are exceedingly essential because of the innumerable contacts a record librarian must make. Her appearance and personality are particularly important when she is dealing with physicians who are sometimes peevish and impatient and therefore most difficult to handle in respect to securing records. The record librarian must have "winning ways" so that she may secure the co-operation she needs in her work.

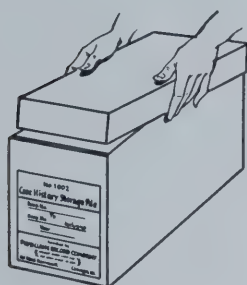
(3) *Tact and diplomacy:*

The importance of tact and diplomacy can hardly be overstressed. You are all aware of the difficulty of keeping the records up to the standard and how easy it is to antagonize doctors, especially those who still believe they should follow their own dictates in regard to writing records or carrying out other regulations in the hospital. To secure the best cooperation from the members of the medical staff, the exercise of tact and diplomacy will be an invaluable asset to the record librarian.

(4) *Accuracy:*

In the work of record keeping the quality of accuracy is exceedingly essential, particularly if statistics are to be

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of any value. Comparative statistics demand the greatest accuracy. It would be wise for the record librarian to keep in mind always the motto: "Accuracy, first, last, and always." All her efforts will be of no avail if she does her work in a slipshod manner. To check and recheck her data should become a firmly implanted habit.

(5) Industry:

The record librarian cannot be lazy or a mere routinist. She must get her records, which means inevitably that she must be constantly on the job. If she is to make her work important and beneficial to the hospital, she must be ever on the job, energetic, interested, keen, alert, and industrious.

(6) Persistence:

The tendency of procrastination in keeping up records calls for a display of persistence from every record librarian who desires to fill her job to the best advantage. There may have to be many attempts to secure records of an acceptable standard. Oftentimes she may have to keep after one person day after day to obtain the record desired. But she must persist or otherwise she will not succeed in getting accurate, prompt, and complete records.

(7) Originality and initiative:

The record librarian, as any other departmental head of a hospital, must be constantly alert to devise new ways and means of improving her work and to carry those changes into effect. She should ever be looking about for newer and better ways of securing records, of filing and cross-indexing records, and other procedures related to the efficiency of the department. This is probably more important in connection with the record department than any other department in the hospital, inasmuch as the keeping of records in a proper, systematic manner has been more or less a development of recent years and there is still much improvement to be made.

(8) Honesty:

It is taken for granted that all hospital personnel must be honest, for if not, the life of the patient may be jeopardized. Of more than minimum importance is honesty necessary as applied to the record librarian. Honest criticism and honest action at all times are most desirable, and this quality should thoroughly characterize every person in connection with the work of the record department.

(9) Cooperation:

Because of the manifold relations and contacts of the record librarian it is incumbent that she maintain a co-operative attitude. Perhaps no other one official in the institution contacts more frequently and more closely with the management, the other personnel of the hospital, and the medical staff both individually and collectively than does the record librarian. Here cooperation is most desirable to warrant a smoother working department.

(10) Progressiveness:

The record librarian should be progressive because there is still much to learn in this special field. An open-mindedness toward the beliefs and experiences of others in her field will stamp her as being a progressive worker. She should always desire to improve her knowledge and experience through seeking information as to what others are doing, attending meetings with her associates, observing the work in other hospitals, reading, and keeping abreast with the modern advances in record keeping.

In listing the qualifications of the record librarian I have not mentioned preparation for this work as might be included under training and experience.

This, of course, is most important. There are very

few standardized and stabilized courses for record librarians as yet, but the Association of Record Librarians of North America is busy working on this project. A few good courses are now offered, but most of the present-day students and even those of the near future will have to learn their work by careful apprenticeship as most hospital superintendents have gained their knowledge. Undoubtedly, many good courses will be available in the future which will offer adequate and satisfactory training for record librarians.

The status and responsibility of the record librarian are now quite clear. She must take her place as the head of a department of the hospital and be responsible directly to the superintendent, as are all other heads of departments. Her contacts are at once both extensive and intimate because of the ramifications of her work in caring for records. She must at all times maintain a very close relationship with the medical staff, the intern or resident staff, the nursing department, the admitting office, the out-patient clinic, the business department, and other divisions of the institution where contact is essential to the successful keeping of the clinical records. Her department must always offer a welcome to anyone legitimately concerning himself with clinical records. The open door, the inviting chair, and the work table in her department should symbolize a welcome to members of the attending and resident medical staffs or others interested in the work for which she is responsible.

TECHNICIANS MOST PROGRESSIVE?

In his presidential address at the Catholic Hospital Association convention at Villa Nova last month, the Rev. A. M. Schwitalla, S. J., said that the association survey of hospitals maintaining schools of nursing indicated that the following percentages of personnel in these institutions were members of national associations in their fields:

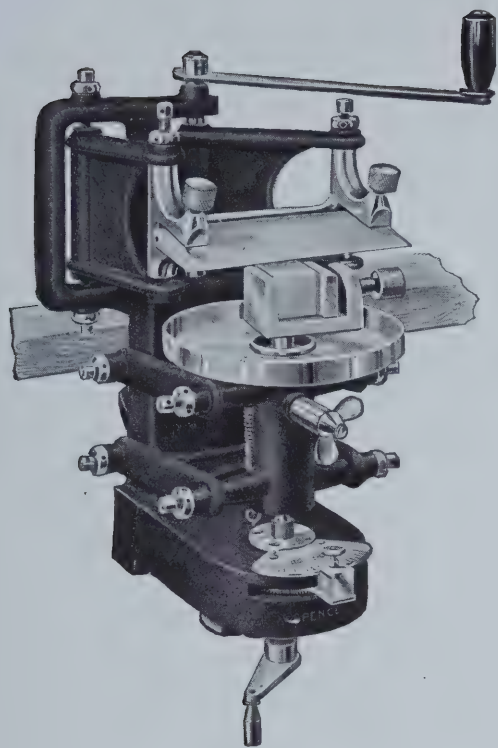
X-ray technicians, 61 per cent.
Laboratory technicians, 47 per cent.
Dietitians, 44 per cent.
Social workers, 12 per cent.
Record librarians, 17 per cent.

Father Schwitalla referred to the educational value of these associations and suggested that all workers in such fields ought to keep in touch with developments and progress through membership in their national groups.

The percentages quoted by Father Schwitalla indicate that X-ray technicians are extremely progressive, leading other personnel by a good margin in relative numbers of members in national associations.

THE HOSPITAL CALENDAR

- National Hospital Association, Los Angeles, August 15.
- West Virginia Hospital Association, Elkins, September 1.
- American Protestant Hospital Association, Detroit, September 9-16.
- American Hospital Association, Detroit, Mich., September 12-16.
- Association of Record Librarians of North America, Detroit, September 12-16.
- American College of Surgeons, St. Louis, Mo., October 17-21.
- Ontario Hospital Association, Toronto, October 26-28.
- Clinic Managers Conference, Mankato, Minn., October.
- Colorado Hospital Association, Colorado Springs, November 8-9.
- Mississippi Hospital Association and Mississippi State Medical Association, Jackson, April 10, 1933.
- Iowa Hospital Association, Marshalltown, April 19-20, 1933.
- South Dakota Hospital Association, Sioux Falls, 1933.
- Western Hospital Association, Long Beach, Cal., 1933.



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The Nursing Department

79 Per Cent of Schools in Public Grading

"THROUGH promises that its findings would be entirely confidential, the Grading Committee was able to induce 70 per cent, or 1,458, of the accredited schools of nursing of the United States to take part in the first grading," says the July A. N. A. bulletin. "No such immunity is being expected by the participants in the second grading, yet 79 per cent are filling out the monthly questionnaires. Statisticians regard this response as indicative of the interest of the hospitals and training schools in learning about and in improving their own situations.

"An outstanding improvement reported by schools in the second grading is the increase in the number of hours of theory that they plan to give their students. On the average the typical school plans to give its students about 130 hours more theory now than it did three years ago.

"Training schools have markedly increased the amount of vacation they are granting their students. In the first grading more than half the schools reported that they gave their students two weeks or less per year, or a total of not more than six weeks during the entire training course. Less than a third of the schools gave as much as three weeks annually. At the present time more than three-fifths of the schools allow their students more than two weeks' vacation, and 43 per cent give them three weeks or more a year.

"The second grading shows a decided increase in the proportion of students who have had four years of high school. Nearly two-fifths of the schools now have all high school graduates as compared with less than one-tenth three years ago. Since the first grading every state in the union has improved its record. In Oregon every student whose record has been received in the second grading is a high school graduate.

"Second grading figures show that in nearly half the training schools in America the students have four hours or less free time during the week. The four hours' freedom is usually given on different days, so that the students have two days a week on which their labor is shortened by two hours. In six per cent of the schools the students work eight hours a day seven days a week, with no time off at all.

"The eight hour day is much commoner for student nurses than is the eight hour night, the Grading Committee finds. This does not mean that nursing has accepted the 48 hour week. In 89 per cent of the schools studied the working week is 49 hours or longer. In nearly half the schools the working week is more than 52 hours long, and in one-fifth of them it is more than 56 hours long. In most schools student nurses are on duty seven days a week.

"As to night duty, 38 per cent of the schools—or nearly two-fifths of all—expect students to work 70 hours a week or more. In only 15 per cent of the schools is the night duty less than 56 hours long.

"Almost all schools give their students 24 hours off

after they finish their night assignment. Very few schools give the students 24 hours off before night duty starts.

"Eighty-two per cent of hospitals reported to the Grading Committee that their training schools are sources of substantial savings each year. The other 18 per cent find the schools are a financial burden to them.

"At the time of the first survey three years ago, 42 per cent of the training schools did not have a regular instructor. In the second grading this figure has shrunk to 22 per cent. In the first grading another 42 per cent of training schools reported that they had only one instructor. That has now grown to 51 per cent. Sixteen per cent of the schools taking part in the first grading had two or more instructors. That number has now advanced to 27 per cent.

"Student nurses in 78 per cent of training schools get a monthly allowance. An additional 10 per cent are paid an allowance but are charged tuition. There is some tendency toward doing away with allowances but not an equally strong tendency toward using the money saved for the benefit of the training schools, the Grading Committee reports. Student allowances range from nothing to \$60 a month, with \$10 the commonest figure. Nearly one-fourth of the schools pay \$10 a month and 12 per cent pay \$15 or more."

Kalamazoo State Hospital Graduates Three

By R. A. Morter, M. D.

Medical Superintendent, Kalamazoo State Hospital,
Kalamazoo, Mich.

Our nurses' graduating exercises were held in our hospital chapel on the evening of June 7. There were only three graduates this year.

The course of study at the Kalamazoo State Hospital School of Nursing extends over a period of three years. High school graduation is required for admission. Graduates from this school are accepted for registration by the state board of registration for nurses upon completing a satisfactory examination before the board.

The laws of the state of Michigan require that the state hospitals conduct a school of nursing. I feel that a school of nursing is a very potent factor in raising the standard of nursing and medical treatment in institutions of this type. Physicians on the staff of this hospital take a great deal of interest in the training school. Each physician gives a certain number of lectures.

We try to create a general hospital atmosphere throughout this institution. We feel that the insane are sick people and are entitled to the same nursing care and medical treatment as a patient in a recognized general hospital.

It may be of interest to know that the Kalamazoo State Hospital is recognized by the American Medical Association as a teaching institution. The school of nursing and training for specialists in nervous and mental diseases are recognized.

We feel that our school for nursing has its place in an institution of this kind and it would be one of the last things that we would want to give up.

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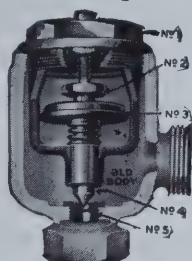
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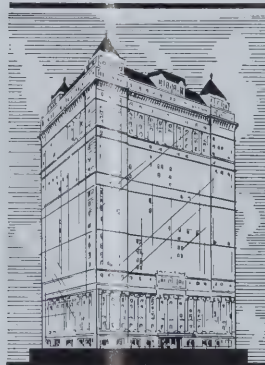
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X-ray, Laboratory Service

Analysis of Charges of 74 Indiana Hospitals

By Edward Rowlands
Indianapolis

IN the preparation of this paper more than 74 questionnaires were returned, 33 from hospitals having 50 beds or less, 12 from hospitals having 51 to 100 beds, 14 from hospitals having more than 100 beds, and the remaining 15 were from state mental hospitals—hospitals connected with correctional institutions and state or county tuberculosis hospitals.

The rates for the private rooms, semi-private rooms, and wards were rather uniform, ranging from \$3.50 to \$7. In nearly all hospitals rooms identical with each other, having the same equipment, etc., but facing the street, rent for \$1 to \$1.50 more. For purposes of comparison I have divided the hospitals into three groups and in each group will give the high and low figures.

	10 to 50 beds		51 to 100 beds		101 beds	
Private room	\$2.50	\$8.00	\$3.50	\$7.50	\$4.00	\$8.00
Semi-private	2.00	4.14	3.00	4.00	2.50	4.00
Ward	2.00	3.00	2.15	3.75	2.00	4.14
Part pay	1.00	3.00	1.45	3.00	1.50	2.08

The next series of questions referred to free services which are included in the room charges.

1. With one exception there is no charge for floor nursing.

2. Twenty of the first group furnished hypodermics free or partially free; 13 charged. Of those in the second group, nine furnished them free or partially free, three charged; and in the larger group only one charged all hypodermics.

3. Fifty per cent of hospitals sending in the questionnaire charged for drugs.

4. Thirty hospitals charged for local telephone calls.

5. All hospitals charged for trays served to guests of the patients or relatives.

6. Fourteen institutions charged for stationery.

7. All hospitals charged for operating room service and the charges were fairly uniform, ranging from \$2.50 for a minor operation to \$15 for a major operation. The average ranged from \$5 to \$15 with one exception, where the fee for a major operation is \$25.

8. Laboratory charges vary in many ways:

a. In three hospitals all urinalyses are free, 10 hospitals give one or two free, and the others charge from 50 cents to \$2 per examination.

b. Wassermanns cost in the first group \$1.50 to \$5; in the second group from \$1 to \$8, and in the third group from \$2.40 to \$5.

c. Blood sugars vary from \$1 to \$5 in the first group; \$3 to \$5 in second group, and in the third from 50 cents to \$5.

d. Compatibility ranges in price from \$2 to \$10 for the smaller hospitals; from \$2 to \$5 for the medium size hospital, and for the larger hospitals \$1 to \$5.

e. Metabolism charges varied from \$3 to \$15 for the first group; from \$3 to \$10 for the second, and from \$3 to \$10 for the third group.

f. Tissue examinations ranged from \$2 to \$5 for the small hospital; from \$2 to \$7 for the middle group, and from \$1 to \$5 for the larger hospitals.

9. X-ray charges were also included in this investiga-

tion and the variation is more pronounced. There are several facts which enter into the X-ray charges and which are here stated. In the questionnaire the hospitals were not asked whether or not the charges were for the taking of the films for the doctor who made his own diagnosis or whether they included the diagnosis by the roentgenologist. In the larger hospitals, as well as many of the other hospitals, there is a full time or part time roentgenologist who supervises the taking of the films and who renders a diagnosis. It is obvious that the hospital having a full time roentgenologist would naturally charge for his service, which would be reflected in the charges for X-ray work. However, in comparison the X-ray charges of the larger hospitals having a trained roentgenologist in charge are smaller than those of the small hospitals having only a technician.

The charges for the three groups are as follows:

Examination	1 to 50 beds		51 to 100 beds		101 beds	
Ankle	\$3.00	\$10.00	\$2.50	\$8.00	\$5.00	\$7.50
Chest	5.00	12.50	8.00	15.00	8.00	15.00
Chest, stereo.....	2.50	20.00	10.00	15.00	10.00	15.00
Colon	7.50	25.00	10.00	15.00	10.00	25.00
Cholecystogram...	7.50	25.00	8.00	15.00	10.00	20.00
Dental, single....	1.00	3.00	1.00	3.00	1.00	3.00
Dental, ea. add....	1.00	2.00	1.00	2.00	1.00	2.50
Dental, full set....	7.50	10.00	8.00	20.00	8.00	16.00
Elbow	3.00	10.00	5.00	10.00	5.00	10.00
Foot	3.00	10.00	5.00	10.00	5.00	7.00
Gastro intestinal...	10.00	35.00	12.00	25.00	17.50	35.00
Hand	3.00	10.00	2.50	5.00	5.00	7.50
Head, stereo.....	5.00	12.50	10.00	15.00	2.00	15.00
Hip	5.00	15.00	8.00	10.00	7.50	10.00
Humerus	4.00	10.00	5.00	10.00	5.00	10.00
Knee A. P. & lat..	5.00	10.00	5.00	10.00	7.00	10.00
K. U. B.....	5.00	25.00	10.00	15.00	8.00	15.00
Leg, below knee...	3.00	10.00	5.00	10.00	5.00	10.00
Mandible	3.00	10.00	5.00	10.00	5.00	10.00
Mastoids	5.00	10.00	8.00	10.00	8.00	15.00
Mastoid, stereo....	5.00	15.00	10.00	15.00	10.00	15.00
Pelvis, single.....	5.00	15.00	8.00	15.00	8.00	15.00
Pelvis, stereo.....	10.00	20.00	10.00	15.00	10.00	15.00
Shoulder, stereo...	5.00	15.00	10.00	12.00	7.00	15.00
Sinuses	5.00	15.00	10.00	15.00	8.00	15.00
Wrist	3.00	10.00	2.50	5.00	5.00	7.50
Spine, 1 film.....	5.00	20.00	8.00	15.00	5.00	10.00
Spine, A. P. & Lat.	10.00	25.00	10.00	20.00	10.00	25.00
Spine, stereo.....	5.00	20.00	10.00	15.00	10.00	15.00
Abdomen	5.00	15.00	8.00	15.00	8.00	10.00
Abdomen, A. P. & Lat.	6.00	25.00	10.00	15.00	10.00	15.00
Clavicle, single....	5.00	10.00	5.00	10.00	5.00	10.00
Clavicle, stereo....	5.00	15.00	10.00	12.00	10.00	15.00
Preliminary & pycl.	7.50	20.00	10.00	25.00	10.00	15.00
Femur	5.00	10.00	5.00	10.00	5.00	10.00
Sella, single.....	5.00	10.00	5.00	10.00	5.00	10.00
Fluoroscopy	2.00	15.00	8.00	10.00	5.00	15.00
Mediastinum	7.00	10.00	8.00	10.00	5.00	15.00
Gall bladder, primary	7.50	15.00	5.00	15.00	5.00	20.00
Sterilization series..	20.00	150.00	...	20.00	...	25.00

or \$3.00 per treatment

This study shows a woeful lack of uniformity in charges. No wonder the patient cannot understand the inequalities of hospital charges.

What can be done about adjusting the charges? We know that it is impossible for all the hospitals to have the same charges. It seems that the best thing to do would be for localities, cities, and other geographical groups to get together and standardize the charges. Several groups have already done this thing, namely, Indianapolis and Fort Wayne; Lafayette is making progress, Evansville is just completing the standardization.

From a paper before 1932 Indiana Hospital Association meeting.

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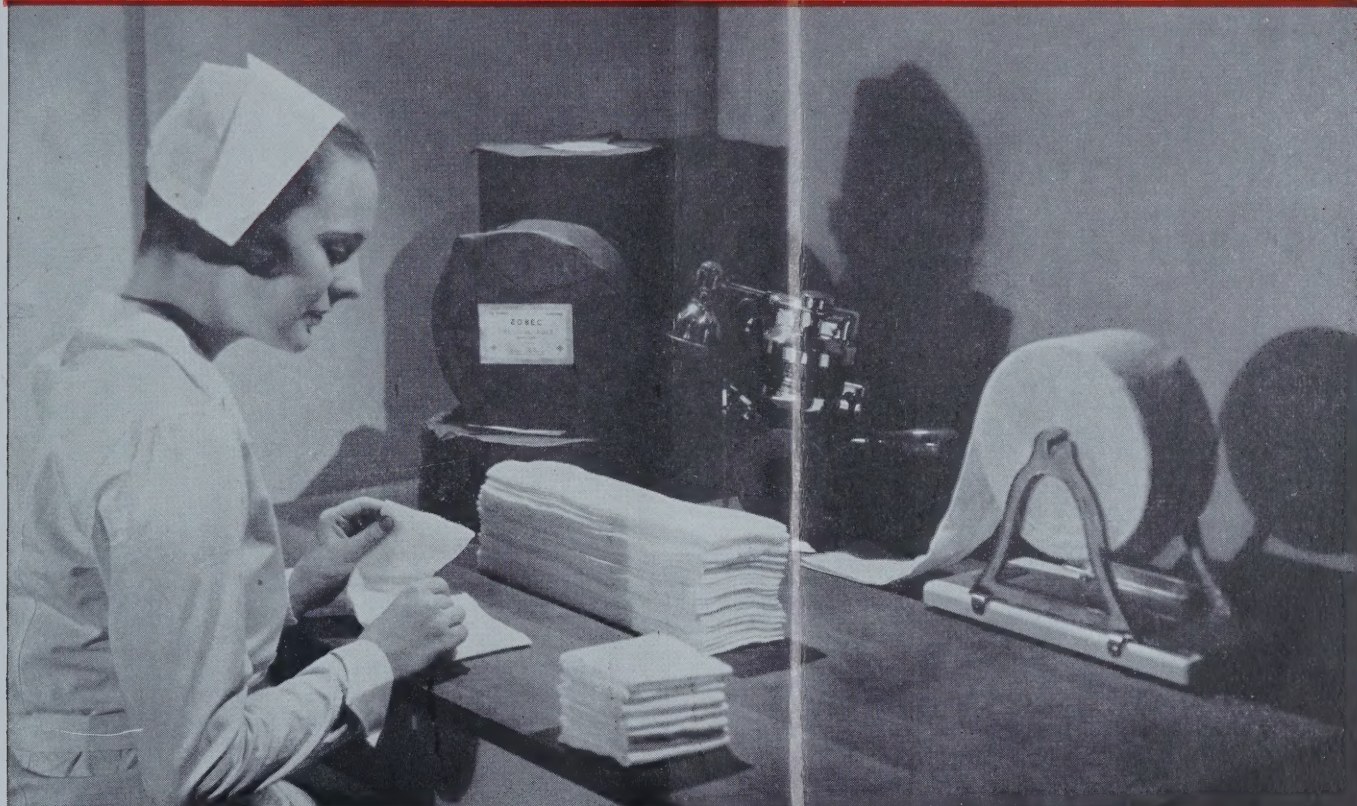
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